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Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment?

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Doctorate of Education

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Abstract

Aim This thesis sets out to explore and understand how nursing students learn in the clinical environment, specifically through the influence of registered nurses.

Background At a time when public confidence in the quality of health and nursing care is called into question, the United Kingdom Nursing and Midwifery Council's (NMC) new standards for pre-registration nursing education are intended to prepare the UK nursing workforce of the future to provide high quality nursing care across a range of health care environments (NMC, 2010b). While existing UK nursing research has examined learning in the clinical environment, little work has been undertaken to understand how nursing students on placement learn in the clinical environment and specifically the influence of others.

Methods Using Yin's (2009) case study approach, this thesis explored the learning experiences of a group of five final year nursing students through descriptions of their learning within the clinical environment. In keeping with Yin's (2009) case study approach of gathering a richness and depth of understanding, additional data were collected from a focus group with eight registered nurses. The collection of two types of data from both learners and registered nurses allowed for an exploration from both perspectives and experiences of these two groups. The interviews and focus group were conducted between October 2010 and January 2011.

Findings The study identified three specific overall themes relating to the influence of registered nurses on student learning in the clinical environment; responsiveness to student learning needs; creating a sense of belonging; and influencing professional identity development. A fourth theme identified was the importance of the clinical environment in that it allows students to learn what cannot be facilitated elsewhere.

Discussion The findings while supporting previous research also provide new understanding. The nursing student participants had and wanted to actively manage their learning in the clinical environment. As a result of this active management the students did not passively acquire knowledge or simply replicate what they observed from others. There was evidence that the students had strong and established perceptions of what constituted 'good' nursing and described an ability to discriminate between differing levels of nursing practice. Student nursing knowledge was gained from respected registered nurses who were best able to describe and demonstrate the 'tricks of the trade' and 'little things that matter' when providing 'good' nursing.

Conclusions The findings have informed a number of suggestions on how to support nursing students and clinical staff to enhance and improve the learning experience in the clinical environment. Curriculum design and preparation of registered nurses and mentors needs to stress the strong social aspects of clinical learning while raising awareness of the importance of creating a sense of belonging and respect for students as individuals. Pre registration curricula need to explicitly explore concepts such as caring, professionalism and support learners to articulate and examine their developing concepts of nursing and what constitutes 'good' and 'bad' nursing.

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Abbreviations Used In This Thesis

A.E.I. – Approved Education Institution

B.E.R.A. – British Educational Research Association

C.A.P. – Continuous Assessment of Practice Documentation

CoCP – Communities of Clinical Practice

DH – U.K. Department of Health

E.N.B. – English National Board for Nursing, Midwifery and Health Visiting

E.S.R.C. – Economic and Social Research Council

H.C.A. – Health Care Assistant

I.V. – Intravenous Infusion

M.D.T. – Multi Disciplinary Team

N.M.C. – UK Nursing and Midwifery Council

O.T. – Occupational Therapist

Physio. - Physiotherapist

U.K.C.C. – United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Chapter 1 – Background And Context

Introduction

This chapter provides the background and context to the identification and development of the research question;

Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?

To answer this question student participants were asked to:

- Recall and describe in their experience, the factors which supported their learning in the clinical environment,
- Identify from their experience the influence of others in their learning, for example clinical staff and mentors, and
- Describe how they identified the learning and experience they needed to gain in and from their clinical placements.

Structure of this thesis

This thesis follows a format that takes the reader through the stages of the work I undertook. Chapter one deals with the context and rationale for selecting the focus of the study which resulted in my identifying three themes related to my area of enquiry: nursing as profession; nursing knowledge and praxis; and finally, becoming a nurse. This chapter draws on my professional experience and thinking supported by the literature that informed the background and context to my research study.

Chapter two describes and critiques the existing literature that guided and influenced the research design. In chapter three, the case study strategy, research methods and data analysis approach are detailed. The penultimate chapter provides the results arising from the student interviews and registered nurses focus group. The final chapter details the application of the results in informing

future nurse education practice and research and concludes with a critique of the research approach I took.

Rationale for and development of the research question

This section is concerned with the three context themes represented in **diagram one** (page 15):

- 1** – Nursing as profession,
- 2** – Nursing knowledge and praxis, and
- 3** – Becoming a nurse.

The themes reflect the issues and challenges for contemporary UK nurse education that I considered, explored and examined during my doctoral studies from 2005 to 2011. The development and completion of my eventual research study was protracted and underwent numerous changes. Changes and alterations to my work are recognised as a result of external influences such as the policy decisions by the U.K. professional regulator, the Nursing and Midwifery Council¹ (NMC) (*table one, page 18*). Additionally my work was developed against the background of reactions from the public, media and regulators to reported incidents of poor quality nursing care.

I accept this as a natural, if not personally frustrating process of developing and progressing a research study. I would argue that my continued refinement and changes made as a consequence of professional developments and my attempts to understand the range of interrelated aspects of my study are a strength of my work. The strength is reflected in my work through the ‘real life’ study approach to undertaking research described by Robson (2002) as,

‘.... seeking to say something sensible about a complex, relatively poorly controlled and generally ‘messy’ situation’ (p. 4)

¹ The UK Nursing and Midwifery Council (NMC) established in 2002 is the professional regulator for nurses and midwives and their role is to safeguard the health and wellbeing of the public. Their remit is set out in the Nursing and Midwifery Order 2001. NMC. (2011). Available: <http://www.nmc-uk.org/About-us/Our-role/> [Accessed February, 20, 2011].

As my work and study progressed, Robson's definition of a researcher guided my attitude and research style, which he described as someone who wishes, '.... to carry out some kind of investigation involving people in 'real life' situations; to draw attention to some of the issues and complexities involved; and to generate a degree of informed enthusiasm for a particularly challenging and important area of work' (2002, p. 3)

Diagram one on page 15 Diagram One – Themes of nursing practice which led to the development of my research question represents the development of my research question from the broad context and wider social and regulatory issues, drawing down to the very specific focus on the examination of the experience of learning on placement and how nursing student learning may be influenced by others in the clinical environment. My original research question was; ***Safety to Practice : Can an Assessment of Self-Efficacy Measure Nursing Students' Clinical Competence ?***

This original research question reflected my early interest in understanding if nursing student practice could be assessed using an established theoretical framework; providing evidence of safe practice. The initial research question focus clearly influenced my reading and early review of the literature and this is reflected in the detail debated in this chapter. My initial focus was on how competence could be assessed through a proxy measure (self-efficacy) with the intention of developing a measure of safety to practice. As my understanding developed as a result of my reading and reflection; I decided that the focus of my research needed to shift to examine the experience of learning rather than focus on assessment of competence. Having considered the literature and professional debates related to competence, I did not believe that the development of an assessment based on competency outcomes would meet my expectation of understanding how to better prepare nursing students to provide safe interventions. The gap in current

knowledge I identified was the lack of exploration, understanding and explanation about the experience of learning by nursing students' in the clinical environment. I considered that it would be of much greater benefit to explore the learning experiences of nursing students and decided that a focus on learning rather than assessment could provide a better understanding of potential interventions and support to improve learning resulting in potentially greater levels of safe practice on first registration.

Diagram one reflects how my initial concern with an overarching question about how nursing students' could be assessed as providing safe nursing care was refined and honed to allow me to research the specific aspect of the influence of others on individual nursing student learning in the clinical environment.

The time invested in refining my question was important to ensure clarity of purpose leading to meaningful outcomes and guard against the warning that, '.... vague questions might lead to vague answers' (Denscombe, 2002, p. 29).

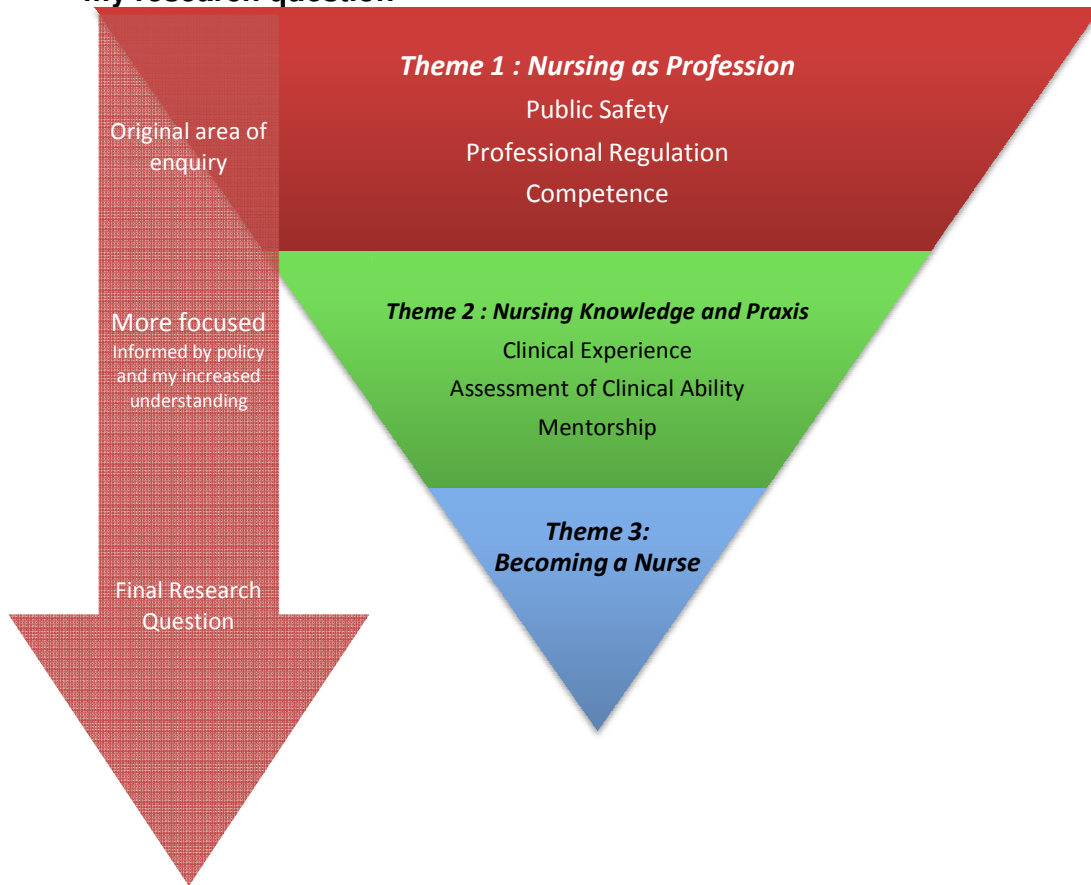
The three theme headings within **diagram one**, nursing as profession, nursing knowledge and praxis and becoming a nurse, provide the structure for the remainder of this chapter.

Theme 1 – Nursing as Profession

This section of the chapter reviews the broader regulatory and professional issues that relate to my study and is structured using the following areas of debate:

- 1** - public safety,
- 2** - professional regulation of nurses and nurse education and
- 3** – competence frameworks.

Diagram One – Themes of nursing practice which led to the development of my research question



Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?

Theme one is important to my study since it recognises and situates the historical, policy and regulatory context of my work. I have titled the theme 'Nursing as profession' to reflect my stance that the public perceptions and attitudes towards nurses combined with the statutory regulators requirements for regulation and educational preparation, provide the elements that encapsulate what the 'becoming a professional' in my research question represents.

Public safety : starting point for my research question

My original research interest relating to nurse education was the facilitation and assessment of clinical competence and arose from new legislation that was passed while I was working as a nurse educator in New Zealand. The New Zealand Health Practitioners Competency Assurance Act (HPCA) became law in

2003 and this new piece of legislation brought together the regulation of all health care practitioners in New Zealand, including previously unregulated groups. Given the title of the Act it was clear that (in New Zealand at least) competence as a concept in professional health care would play a crucial and increasing role in how the public, employers and health professionals themselves view and define their practice. This shift in New Zealand, towards a greater accountability of health care workers for their on-going updating and demonstration of safe and current best practice, and ability to maintain their competence was driven by a desire to improve public safety. This approach chimed with similar policy developments in many other Western countries, including the U.K. (Watson and Thompson, 2000, Kitson, 2001).

In 2005, I returned to the U.K. to live and work as an education leader within a Faculty of Health and as a result, my research was influenced and directed by changes within the U.K. nurse education system. Changes to my work were informed with the introduction by the N.M.C. of core clinical clusters for all nursing programmes (NMC, 2007). The N.M.C. decision to review the structure and content of pre-registration² nurse education in the U.K. was another significant influence of my research planning. In February 2011, the U.K. Health Ombudsman's office³ produced a report that detailed the real life cases of ten older people who had received sub standard hospital care (Ombudsman, 2011a). In the forward to this document, Ann Abraham, the health ombudsman stated that the patient stories provided in the report,

‘..... present a picture of NHS provision that is failing to respond to the needs of

² The term ‘pre-registration nursing education’ describes the programme that a nursing student in the United Kingdom undertakes in order to acquire the competencies needed to meet the criteria for registration with the Nursing and Midwifery Council (NMC)

³ Provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England have not acted properly or fairly or have provided a poor service. OMBUDSMAN. (2011b) *Parliamentary and Health Service Ombudsman - About us* [Online]. Available: <http://www.ombudsman.org.uk/> [Accessed 18/02/2011].

older people with care and compassion and to provide even the most basic standards of care’

(Ombudsman, 2011a, p.5)

The Ombudsman’s report was published at a time when it could be argued that public confidence in the health care service, health care professions and nursing in particular was already at a low level. The Ombudsman’s report followed earlier investigations of poor patient care at Maidstone and Tunbridge Wells NHS Trust (HCC, 2007). Equally critical of nursing care, the Healthcare Commission investigation on deaths at Mid Staffordshire Hospital (HCC, 2009) was described in the media as the,

‘.... Mid-Staffordshire Hospital Scandal’ (Kite, 2010)

The earlier case of general practitioner Harold Shipman who, in the late 1990s was named Britain’s worst serial killer, provided another very tangible example to the general public of the potential danger posed by unsafe health care professionals (Horton, 2001, McKinley et al., 2001). This section of the chapter outlined the background and motivation for this study. The next section will explore how the N.M.C. as professional regulator has developed education standards to provide assurance of safe and competent practitioners at the point of initial registration.

Professional regulation : shaping nursing as profession

It is of note that U.K. nurse education had undergone a number of significant revisions between the years 1986 to 2010 and into 2011 with the introduction of an all-graduate qualification requirement for entry to the professional register coming after a long debated history on the need for a graduate nurse education (Brooks and Rafferty, 2010). **Table one** provides a timeline of the key changes and the relevant policy documents I identified as important in informing my study. Often,

these reviews were driven by anticipated future changes in the future health care needs such as an ageing population, health care system reform and restructures, changing workforce demographics and importantly, concerns in the late 1990s and into 2000 about the ability of newly registered nurses to provide professional and safe patient care (DOH, 1999).

Table One - Historical developments in UK nurse education
Nurse Education Policy Documents 1986 to 2010

Time Frame	Policy	Key Elements/Changes	Policy Owner
1986	<i>Project 2000: A new preparation for practice</i>	Supernumerary status for students A common foundation element of 18 months followed by a final 18 months branch specific learning. Minimum of diploma level education	U.K.C.C. ⁴
1992	<i>Further and Higher Education Act</i>	Non-employed status – student bursary Overall changes to funding and administration of further and higher education in the U.K. 35 UK polytechnics were allowed to become Universities	Act of Parliament
1999	<i>Making a difference : Strengthening the nursing, midwifery and health visiting contribution to health and healthcare</i>	Creation of HEFCE – funding Council for Higher Education and FEFC for Further Education Specific to education: To develop a system of nurse education responsive to the needs of the NHS Increase the level of practical skills in training programmes Widen access to nurse education, particularly for under-represented groups Create more flexible career pathways into and within nursing and midwifery	Department of Health (D.H.)
1999	<i>Fitness for Practice 'Peach Report'</i>	15 Key Issues identified, those relating to clinical learning; the perceived imbalance of the common foundation programme (CFP) the perceived imbalance between theory and practice the variable nature of practice placements variable support for student learning in practice placements management of the student experience	U.K.C.C.
2000	<i>Standards for the Preparation of Teachers of Nursing, Midwifery and</i>	Section 2 of the document set out the UKCC/NMC advisory standards for preceptors and for mentors	UKCC/NMC

⁴ Established in 1983 the United Kingdom Central Council for Nurses Midwives and Health Visitors (UKCC) with core functions to maintain a register of UK nurses, midwives and health visitors, provide guidance to registrants, and handle professional misconduct complaints. Replaced in April 2002, by the Nursing and Midwifery Council (NMC)

2000	<i>Health Visiting A Health Service of All the Talents: Developing the NHS workforce</i>	Placed clear responsibility on employers and the new Workforce Development Confederations to establish good quality practice placements.	D.H.
2001	<i>Placements in Focus: Guidance for education in practice for health care professions</i>	<p>The aims of the publication were reported as intended to;</p> <ul style="list-style-type: none"> • enhance and build on existing guidance and standards relating to practice placements • improve the quality assurance procedures relating to students' practice experience • focus on common expectations across the health care professions • support the development of innovative ways of increasing and making best use of practice placements which reflect the varied communities and situations in which health care professionals work • share ideas about the identification and development of new opportunities for practice experience • facilitate communication between health and social care professionals on practice placement issues. (ENB, 2001) (p. 5) 	E.N.B. ⁵ / D.H.
2001	<i>Preparation of Mentors and Teachers A new framework of guidance</i>	<p>The report was written to 'provide practical, contemporary guidance for the development of mentor and teacher preparation programmes' with the reported Aims;</p> <ul style="list-style-type: none"> • clarify the educational framework for mentor and teacher preparation • provide guidance for institutions planning and offering mentor and teacher preparation programmes • provide guidance for individuals wishing to undertake a mentor or teacher preparation programme • indicate ways in which health care professionals can plan for and obtain a teaching qualification • share approaches supporting the development of teachers • identify the link with membership of the Institute for Learning and Teaching in Higher Education (ILT) – <i>which later became the Higher Education Academy (HEA)</i> <p>(ENB and DH, 2001) (p. 6)</p>	E.N.B. / D.H.
2004	<i>Standards of Proficiency for Pre-Registration Nursing Education</i>	'The standards of proficiency define the overarching principles of being able to practise as a nurse; the context in which they are achieved defines the scope of professional practice. Applicants for entry to the nurses' part of the register must achieve the standards of proficiency in the practice of adult nursing, mental health nursing, learning disabilities nursing or children's nursing.' (NMC, 2004) (p. 4)	N.M.C.
2006	<i>Modernising Nursing Careers – setting the direction</i>	<p>Four Key elements identified for nurses in response to changing demands on the health service</p> <ul style="list-style-type: none"> • Practice • Education, Training and development 	Chief Nursing Officers of the UK

⁵ ENB – English National Board was established in 1983 main functions were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on these courses. Abolished in 2002 with establishment of the Nursing and Midwifery Council (NMC)

		<ul style="list-style-type: none"> • Quality and service development • Leadership, management and supervision <p>15 key shifts indicated from position in 2006 to future approach indicated in the report.</p>	
2007	<i>Guidance for the introduction of the Essential Skills Clusters for Pre-Registration Nursing Programmes</i>	The ESCs were developed as an outcome of the Review of fitness for practice at the point of registration and were developed to 'provide clarity of expectation for the public and profession alike and seek to address some of the concerns about skill deficits arising from the Review' (NMC, 2007) (p.3)	N.M.C.
2008	<i>Standards to Support Learning and Assessment in Practice</i>	<p>Built on earlier work from <i>Standards for the Preparation of Teachers of Nursing, Midwifery and Health Visiting</i>. Provided a framework for clinical education.</p> <p>Defined role and function of mentors. Framework with eight domains ;</p> <ol style="list-style-type: none"> 1 Establishing effective working relationships 2 Facilitation of learning 3 Assessment and accountability 4 Evaluation of learning 5 Creating an environment for learning 6 Context of practice 7 Evidence-based practice 8 Leadership <p><i>Other key and new developments;</i> Sign Off Mentors Local Register of Mentors Triennial Review of Mentors</p>	N.M.C.
2010	<i>Standards for Pre-Registration Nurse Education</i>	<p>Degree in Nursing as minimum outcome award (previously diploma award)</p> <p>No specific requirements for nature or range of practice learning - must support competencies to be gained</p> <p>Must be two progression points – separating programme into three equal parts</p> <p>Competency Framework based on four domains</p> <p>Generic and Field Specific (Adult, Child, Learning Disability and Mental Health) knowledge and skill competencies</p>	N.M.C.

While **table one** provides a useful summary of the range of policy developments in relation to UK pre-registration nurse education, it more importantly demonstrates that a significant number of changes and revisions have been made to the structure and development of UK nurse education over the past 25 years. The range and number of policy documents detailed, provides an indication that nurse education has received a significant amount of political and policy attention and the potential negative impact on learners and clinicians from frequent and wide ranging education revisions and changes should not be underestimated.

It is of interest to my research that as early as 2001, the English National Board (E.N.B.) report on placement learning recognised and made the recommendation that,

‘.... staff within the environment must provide good role models, they should value learning and should enable students to reflect on their practice.’

(ENB, 2001, p. 11)

While this report is now ten years old, there was recognition of the need for clinical staff to act as positive role models, reflecting good quality nursing care while recognising the importance of their role as educators to support student learning. I make the assumption that given the specific reference to the need for there to be good clinical role models who value learning, it was recognised at the time of the report in 2001 that, clinical teaching and learning from others in the clinical environment was perceived as not happening sufficiently or adequately enough (UKCC, 1999, Beecroft et al., 2006).

It is also worth noting that shortly after the publication of *Preparation of Mentors and Teachers: A new framework of guidance* (ENB, 2001), the ENB was abolished as part of the creation of the new Nursing and Midwifery Council. In chapter two, I highlight where the later literature indicates that the aspirations laid out in the ENB report on placement learning (ENB, 2001) were not universally implemented or realised. Some of the other reports identified in **Table one** will be referred to later in this thesis to provide a policy context for the arguments and critique presented and discussed.

Competence : defining nursing practice ?

Health care employers, the public and governments expect newly qualified nurses to demonstrate fitness for practice⁶, fitness for purpose and fitness for award (Flanagan et al., 2000). Such is the general and public interest in how nurses are prepared for professional registration, the popular media have coined headlines such as ‘too clever to care’ and ‘too posh to wash’ (BBC, 2004) and the associated

⁶ Relates to an individual who has the health and character, as well as the necessary skills and knowledge to do their job safely and effectively. NMC (2010b). Standards for pre-registration nursing education. London: Nursing and Midwifery Council, HPC. (2011) *Fitness to practise* [Online]. Available: <http://www.hpc-uk.org/complaints/ftp/> [Accessed February 23 2011].

use of 'hidden camera' exposé television programmes claiming poor levels of nursing care (Marsden, 2011). The point was well made by McKenna et al. (2006) that there is never complaint about physicians having too much knowledge or being over qualified in the way that nurses are criticised for having higher levels of education. There remains a tension for the public and the nursing profession in relation to how best to prepare and educate 'knowledgeable doers' reflecting the need for nurses to maintain a wide knowledge base; technical ability and skills range to provide nursing care. Many of the current criticisms about the perceived deficits in nursing care are related to the introduction of a more academic nursing programme delivered at diploma level (Watson and Thompson, 2000, Meerabeau, 2004), led by the *Project 2000* policy in 1986 (*table one, page 18*). This debate about the academic nature of nursing preparation highlights the tension between the expectation that nurses will have both clinical skills combined with a strong technical and theoretical knowledge base while maintaining a strong compassionate and caring focus to their work (Solvoll and Heggen, 2010).

The professional regulator's decision to have provision of an all-graduate preparation (NMC, 2010b) from September 2013 builds upon previous work and revisions to the pre-registration nursing curriculum. Previously, Watson et al. (2000) were critical of plans resulting from revision to U.K. nurse education suggested in the *Fitness to Practice* report (*table one, page 18*) which reduced the nursing diploma programmes foundation theory component by six months, an approach which they claimed,

'.... virtually removed the educational component of nurse education and replaced it with training in clinical competence' (p.1041).

Much of the drive for a reduced theory component was based on an argument for students to have greater clinical exposure and experience. There appears to be an implicit expectation that a greater time spent in the clinical environment will have a

positive influence of nursing students' learning and ability to provide safe nursing care. Part of the debate and focus on nurse education is the NMC requirement that adheres to European Union legislation of a minimum 2,300 hours of clinical placement, representing at least half the total course learning (EU, 2005). With such a significant amount of course time spent in the clinical environment, the need to ensure that the learning that occurs on placements is effective and beneficial to a student's development is clearly crucial to achieving the learning outcomes required.

Since the early Eighties there has been an increasing emphasis and focus within health care education and practice towards the development, measurement and assurance of clinical competence with a number of authors and researchers exploring the need for clarity around the competence of nursing students. Some of the recurring themes identified were; the inability of newly qualified nurses to provide safe clinical nursing care and skills (Bradshaw, 1997, Bradshaw, 1998, Bradshaw, 2000a, Bradshaw, 2000b), the assessment of competence of nursing students (Chambers, 1998, O'Connor et al., 1999, Flanagan et al., 2000, Norman, 2002, Redfern et al., 2002, Watkins, 2000, Watson, 2002, Watson et al., 2002a, Watson et al., 2002b, Dolan, 2003), the developing role of nursing and the education levels and standards required to meet this need (Manley, 2000, Bartlett et al., 2000, Watson and Thompson, 2000, Watkins, 2000, Winters et al., 2003) and the perception that current nursing students lack a vocational or caring approach to nursing (Solvoll and Heggen, 2010).

Watson (2002) argued against the adoption of competencies within nursing education and saw the move towards competency based education as an '.... anti-educational mentality' (p.476).

Watson's (2002) argument for this stance lay in what he believed was the false public and political belief that degree or university educated nurses were

‘.... too clever to care’ (p.476)

The anxiety around a move towards competency or skills based learning was, I believe seen and perceived by some as a signal of a return to a training rather than educational preparation for nursing students with an overreliance on ‘doing’ and limited recognition of the knowledge and decision making skills needed for the future health care workforce. The argument that competence is unable to capture and reflect the complex nature of nursing practice is explored in the next section.

The complexity of practice : standards for nurse education

I would argue that a purely competence approach to learning is educationally reductionist and fails to reflect the nature of autonomous professional practice, due to the high level emphasis put on gaining and assessing clinical skills at the risk of ignoring or not supporting deeper thinking and decision making abilities a view that is supported by Tiwari et al. (2005). While reflecting a different professional group, in their paper exploring the experiences of newly qualified UK teachers based on a standards model of preparation for a teaching role, Yandell and Turvey (2007) suggested that the statutory list of teaching competencies had, ‘.... tended to lead to a mechanistic assessment of trainees against each individual standard’ (p.534).

The argument presented by Yandell and Turvey (2007) reflects one potential outcome of a competence led curriculum, which Eraut (1994) argued led to the certified assurance of competence achieved and demonstrated through end point summative assessment. While the outcome of certified competence may appear to deliver on the agenda of assuring public safety, I suggest that a focus solely on certified competence is counter intuitive to the concept of autonomous professional practice (Darbyshire and Fleming, 2008). The view that professional practice and associated knowledge is more complex than represented by a

competence approach to learning was supported by Delandshere and Petrosky (2004) who questioned the

‘.... assumption that knowledge is a commodity that can be objectified, represented in the form of standards, and measured in terms of immediately visible outcomes ’ (p. 5).

The central concern about professional practice and standards or competence based learning and assessment reflected in the literature relates to an over simplification of complex practice. While Blake and Lansdell (2000) were writing about teaching practice, their comment is equally relevant to nursing when they described teaching standards as,

‘.... maybe too discreet, losing sight of the wholeness of teaching performance’ (p. 64).

I would argue for a similar position in relation to nursing where the desire to develop, independent, autonomous and confident lifelong learning professionals is as important to assuring quality nursing care and public safety as the demonstration of a set of nursing skills (Roberts, 2009b).

The future of UK nurse education : 2011 and beyond

In the new education standards to be implemented from 2011 with all programmes meeting the requirements by September 2013, the UK Nursing and Midwifery Council identify four sets of competency domains underpinning nursing care;

- Professional values,
- Communication and interpersonal skills,
- Nursing practice and decision making and
- Leadership, management and team working

(NMC, 2010b, p. 7)

The new NMC competencies were intended to provide a framework to structure nurse education with all UK programmes validated and approved to the new

standards by September 2013. The four competency areas were introduced to provide new opportunities to frame the clinical environment learning outcomes. It would be interesting to understand if students currently undertaking a nursing programme could demonstrate these four competency requirements since I suggest that the four domains are fundamental to nursing care and it would be of concern if learners undertaking current programmes could not also achieve and demonstrate these four domains of practice. Equally important is how the four domains can be facilitated and learnt in the clinical environment.

The UK Nursing and Midwifery Council, have identified in their Standards for pre-registration nursing education that,

‘competence is a requirement for entry to the NMC register’

(NMC, 2010b, p. 11)

and in doing so, I suggest indicates that the NMC view the demonstration and certification of competence as a key aspect of ensuring public safety since ‘competence’ is aligned to eligibility to apply to enter the professional register, the process used by the NMC to manage public safety.

The NMC offer a definition of competence as a holistic concept that is defined as,

‘.... the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions’

(NMC, 2010b, p. 11)

It is an interesting and new application of the term ‘competence’ to be applied as an overarching concept of ‘completeness’, a bringing together of a range of distinct and discreet skills sets and personal qualities into a composite of a professional nurse. While this approach to defining competence provides a position to work from, the adoption of this definition fails to support or deal with the issues and challenges relating to the assessment of competence, especially in the clinical environment, which will be discussed in the next section.

Theme 2 – Nursing Knowledge and Praxis

The previous section of this chapter had as a focus the broad social and regulatory concerns relating to my research question; ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

This segment of chapter one will take the debate to the second level indicated in **diagram one** (page 15) by discussing the key issues I identified associated with providing and supporting clinical education for nursing students. I have adopted the term 'praxis' to capture and reflect the complex nature of the clinical environment. There are a number of terms that I could have applied such as practice, placement or clinical. However, none of these terms represented to me the complex nature of nursing care. While acknowledging that 'praxis' is a contested term (Penney and Warelw, 1999), I have adopted it since the term praxis represents for me, the complexity of nursing and the nursing role and at the same time attempts to recognise the relationship between theory, practice and an individual nurse's practice.

Clinical experience : learning in the clinical environment

The role of facilitating learning in the clinical setting is challenging. By its' very nature, learning facilitation and assessment in the 'real world' of clinical care is problematic for a number of reasons, for example; the risk of exposing the public to unsafe care from novice care providers, the unpredictable nature of the clinical environment and therefore the risk of not providing adequate and fair opportunities for learners to learn and be assessed. The current models of clinical teaching and support mean that learners are most likely to be facilitated in their learning (or not) and formally assessed by a range of clinical staff who undertake a teaching and assessing role alongside their 'main' clinical/nursing activity (O'Callaghan and

Slevin, 2003), which can result in teaching and assessing being viewed as an additional burden to clinical staff and mentors⁷. If students were perceived as a burden and teaching not part of the registered nurse role, learners may not have optimal learning opportunities, may not be welcomed within clinical teams and could be 'blamed' for excessive additional staff workloads and resultant poor nursing care.

Assessment of clinical ability : ready to be a nurse

Aligned to the shift towards a greater competence focus in nursing courses was the long standing and on-going debate on how to effectively assess clinical competence to assure that newly qualified nurses had the appropriate knowledge, skills and attitudes to provide effective nursing care (Fitzpatrick et al., 1993, Girot, 1993a, Bradshaw, 1997, Bradshaw, 1998, Chambers, 1998, Nicol and Freeth, 1998, Bartlett et al., 2000, Bradshaw, 2000a).

As an educator, I was initially concerned by the apparent lack of robust assessment approaches to the measurement of competence within nursing curricula. In presenting my early reviews of the literature I received positive feedback from peers on the professional concerns relating to the implementation of a competency curriculum framework and assessment approach to nurse education (O Luanaigh, 2004, O Luanaigh, 2005). This shift in educational thinking was very possibly due to concerns raised in the early to mid nineties by authors such as Girot (1993a) who had highlighted concerns about the perceived lack of rigour in assessing nursing students within the clinical environment. Wellard et al. (2006) over ten years later, continued the debate and identified the need to,

⁷ An NMC mentor is a registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an AEI as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes. NMC (2008b). Standards to support learning and assessment in practice. London: Nursing and Midwifery Council.

'.... develop systems of appropriate assessment to ensure that graduates of nursing demonstrate adequate knowledge and competence to enter the profession' (p.68).

I suspect that very few educators, health employers or indeed the public would disagree with this statement. The challenge of course is *how* to and *what* kind of assessment or assessments could achieve this outcome and provide the level of assurance wanted.

The literature I reviewed indicated that currently there is a range of differing approaches to assessing ability, performance or competence in the clinical environment. At best, some nursing programmes use a triangulation of information such as practice assessor feedback, student self-assessment and controlled practical testing to identify student achievement (Watson et al., 2002b).

At the other extreme, practice assessments often consist of a series of pass/fail statements, which are completed by a practice assessor or mentor. The issue of competence assessment is complicated within nursing due to the fact that many of the standards fragment nursing care into a list of functions or outcomes with a focus solely on clinical skills and performance of 'tasks' in the clinical environment. This approach I believe, leads learners to view their experience in the clinical environment as a segmented and purely task acquisition experience (O'Callaghan and Slevin, 2003). As a result, there is a risk that nursing students will not seek to develop a unified or holistic approach to providing nursing care, by drawing on and combining inter-personal, assessment and clinical skills. This approach to learning fails to reflect the holistic concept of competence adopted by the Nursing and Midwifery Council (NMC, 2010b).

While there is a legitimate requirement to protect the public when providing students with an environment where they can learn to be a nurse, there is a tension between how authentic learning experiences can be gained in a

completely safe environment. I believe the current focus on certification and assurance of demonstrating skill sets has removed the emphasis on the concept of professional self-awareness and personal accountability for learning and on-going professional clinical ability (Ashworth and Morrison, 1991). The current clinical environment and skills approach to assessment has led it could be argued, to the situation where what is assessed may not relate to what students are expected to do once qualified (Boud, 1995). There is a risk that competence frameworks lead to an assessment approach, which focuses on the task rather than deeper learning and integration of knowledge and skills. I would argue that professional curricula and their associated learning and assessment must support learners to develop an integrated approach to providing nursing care and not with a focus purely on skills attainment. The new NMC requirements discussed previously, in my opinion do set a more supportive approach to the integration of learning in explicitly stating that the prescribed level of competence required relies on the,

‘.... combination of skills, knowledge and attitudes, values and technical abilities’ (NMC, 2010b, p. 11)

Equally, mentors who also act as assessors may facilitate learning to focus purely on gaining discreet clinical skills without conveying or supporting the extended context of patient care and decision making. This may be particularly true for registered nurses who themselves were educated within a competency framework. Later (page 59), I discuss student dissatisfaction with a focus on tasks and ‘doing work’ when in the clinical environment and I suggest that there is a possible link with this competency approach to learning and assessment resulting in student perceptions of a task and fragmented approach to nursing care. This may well be the key reason why current competence frameworks fail in my opinion, to support comprehensive, individualised and holistic understanding of nursing care. If this is

truly the case then one way to deal with the risk of teaching fragmented approaches to nursing could be to develop the ability of mentors and clinical staff to teach and support the discrete aspects of a competence framework within the wider context of care provision (Chambers, 1998, Chesser-Smyth, 2005, Fitzgerald et al., 2010).

Duffy (2003) coined the expression 'failing to fail' as a result of her study into the assessment and grading of UK nursing students by their mentors in the clinical environment. Duffy's work (2003) identified that mentors had difficulty in failing nursing students even when they had concerns about a student's ability to provide safe nursing care. There is evidence that seven years later the issues identified by Duffy (2003) where mentors expressed difficulty in failing students remains unresolved (Gainsbury, 2010). Gainsbury (2010) reported a *Nursing Times* survey of nearly 2,000 nursing mentors where 37 per cent of the mentors surveyed claimed that they had passed students who they felt should have failed. Mentors felt that the amount of effort required to fail a student was too onerous and there was also a perception that the student's university would overturn any decision made by the mentor. The main reasons cited by the mentors who participated in the survey for wanting to fail a student were when a student's competence (broad term) or attitude (or perceived lack of professionalism, I would suggest) concerned them (Gainsbury, 2010).

In their study exploring the relationship between clinical assessment and clinical learning, Tiwari et al. (2005) captured participant perceptions using focus groups with 38 individuals. The participants included nursing students from across the programme years, mentors, clinical educators and graduates. The overarching finding of their work was that all participants perceived that what students learned during a clinical placement was determined by the clinical assessment tasks. The implication of this on student development could be that learning is constrained by

the assessment. This study had a reasonable number of participants and usefully did capture the views of a range of individuals from students, mentors and graduates and there appeared to be a strong consensus that student learning in the clinical environment was heavily influenced and structured in response to the assessments they needed to complete. As a result of this approach the students adopted learning strategies to achieve success in the assessments and this had the impact of limiting student learning and skill development to reflect the assessment tasks (Tiwari et al., 2005). While it may appear reassuring that student learning in the clinical environment is shaped by their clinical assessments, this assumption is based on the nature of the assessment reflecting the range of skills required and needed. Building on the earlier debate relating to mentors 'failure to fail' it could be argued that the UK approach prior to the revised NMC education standards (NMC, 2010b) had the potential to result in generations of nurses not having optimal clinical learning opportunities. The cumulative impact of this situation would be that nurses educated in a 'failure to fail' environment become mentors and replicate their experience and perpetuate a downward cycle in terms of teaching and assessing effectively in the clinical environment (Farley and Hendry, 1997, Bourneuf and Haigh, 2010, Taylor et al., 2010).

My stance is that there should be a much greater focus and energy on how to best facilitate and support learning in the clinical environment. The past twenty years has seen a recognition that UK nursing and nurse education has suffered from a hierarchal and asymmetrical approach to learning which does not support or foster autonomous student learning and is contrary to the concept of professional practice and accountability (Darbyshire and Fleming, 2008). The prevailing approaches to supporting learning and teaching in the clinical environment have the negative potential I believe to reduce the opportunities students have to gain

the integrated knowledge and skills needed to allow them to function as registered nurses.

Mentorship : the role of others in nursing student learning

Mentors and mentoring have been identified as key elements of UK nursing curricula and programme delivery for the past 20 years (Myall et al., 2008) and the allocation of a mentor is a mandatory requirement for all UK pre-registration nursing and midwifery students on every clinical placement (NMC, 2008b).

Interestingly and possibly not surprising, there has remained as much debate and disagreement about the function and role that mentors should and do provide as there is regarding the debate on assessment of competence which was covered earlier in this section (Monaghan and Lunt, 1992, Earnshaw, 1995, Andrews and Wallis, 1999, Lloyd Jones et al., 2001, Pellatt, 2006, Barker, 2006, Beecroft et al., 2006, Mallik and McGowan, 2007, Myall et al., 2008). In their review of the use and perceptions of the mentor role across a range of disciplines, Monaghan and Lunt (1992) noted the central theme within nursing of a mentor acting as an educational resource who,

‘.... enhances learning and promotes certain values’ (p251).

Monaghan and Lunt’s perspective reflects the NMC standards for mentors (NMC, 2008b) while more explicitly stating the mentor role as promoting and possibly extolling ‘certain values’. The NMC requirements have the additional emphasis on the role of mentors who,

‘.... will assess competence in practice and confirm that students are capable of safe and effective practice’ (NMC, 2008b, p. 13)

While previous studies have recognised the competing and conflicting definitions and concepts about what mentoring is or should be, the issue in the U.K. is somewhat closed with the regulatory body’s publication of their guidance and

requirements for mentor support in *Standards to support learning and assessment in practice* (NMC, 2008b). The Nursing and Midwifery Council in their *Standards to support learning and assessment in practice* identify that mentors are responsible and accountable for;

- Organising and co-ordinating student learning activities in practice,
 - Supervising students in learning situations and providing them with constructive feedback on their achievements
 - Setting and monitoring achievement of realistic learning objectives
 - Assessing total performance – including skills, attitudes and behaviours
 - Providing evidence as required by programme providers of student achievement or lack of achievement
 - Liaising with others (e.g. mentors, sign-off mentors, practice facilitators, practice teachers, personal tutors, programme leaders) to provide feedback, identify any concerns about the student's performance and agree action as appropriate
 - Providing evidence for, or acting as, sign-off mentors with regard to making decisions about achievement of proficiency at the end of the programme
- (NMC, 2008b, p. 19)

While these standards provided clarity and a consistent approach to identifying the mentor role, the seven responsibilities identified have a bias towards assessment, monitoring and confirming achievement of proficiency. There is limited reflection of a teaching role and no explicit recognition of the potential role that mentors could or should play in influencing learning.

The final section of this chapter explores how students may experience 'becoming a nurse' and discusses the application of a social theory of learning to explain the student learning experience in the clinical environment.

Theme 3 – Becoming a Nurse

My research question, ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

is concerned with the nursing student as a learner and seeks to understand the reported experiences by final year nursing students⁸ of their learning during clinical placements. I chose final year students since they would be expected to have the greatest amount of experience and strongest developed professional identity as they approached completion of their course and first registration.

The role of clinical staff in influencing student learning is reflected in the literature with significant research exploring the role of registered nurses, mentors, peers and others in supporting nursing student learning in the clinical environment (Barker, 2006, Myall et al., 2008, Shakespeare and Webb, 2008, Ousey, 2009, White, 2010). There is within the literature, limited examination evident relating to if and how established and permanent clinical team members have an influence and impact on nursing students' learning. In trying to gain an understanding of how learning may be influenced by others, I chose social theory of learning as one possible theoretical framework to inform my research design and analysis of the results.

A social theory of learning : understanding the becoming

In exploring and reviewing an appropriate theoretical framework to assist me to understand the elements of my research question, I was aware of the need to use a theory of learning that could help me to understand and explain how interaction with others in a clinical environment might influence nursing students learning.

I chose the social theory of learning supported by Wenger (1998) who argued that fundamentally learning was a social phenomenon. The event of learning for

⁸ Final year nursing students were those completing a three-year undergraduate UK nursing course and were undertaking the final six months of study prior to finishing.

individuals was described as happening as a result of a process,

‘.... of being active participants in the practices of social communities and constructing identities in relation to these communities’ (Wenger, 1998, p.4)

This definition was relevant for my research due to the recognition of learning needing to require active participation by individuals, which I believe resonates with professional and adult learning. As adults I believe there is a responsibility and motivation to seek knowledge and learning and the use of the term ‘participant’ reflects for me the joint role and responsibility of student and teacher to facilitate learning. In my research question the term ‘Becoming a professional’ reflects my belief that during the course of a nursing programme, nursing students create a professional nursing identity and at the point of first registration, the expectation by the professional regulator, the public and the individual student is that they have ‘become’ a nurse (ENB, 2000). I perceive ‘professional’ to encompass the values, attitudes and skills identified as critical by the UK Nursing and Midwifery Council in their four core competencies, in particular the competency of ‘Professional values’ (page 59). The Nursing and Midwifery Council’s professional values domain for example, requires new registrants to demonstrate,

‘.... professionalism, integrity and caring’ (NMC, 2010b, p. 13).

Wenger’s (1998) definition clearly recognises the importance of identity creation as a central aspect of learning, providing support for my claim that nursing students should have developed the identity of being a nurse on completion of their studies.

This view was supported by the E.N.B. (2000) who reported that,

‘Becoming a nurse involves more than the learning of a body of knowledge and a range of skills. It involves becoming a nurse, a certain type of person whose very identity is constructed and maintained through nursing practice’ (p. 2).

In recognising the differing theoretical positions on adult learning, in the context of

this research project I have adopted the definition of learning provided by Wenger (1998), who stated that learning,

‘.... changes who we are by changing our ability to participate, to belong, to negotiate meaning’ (p. 226)

I chose this definition of learning because it reflects my view of learning and resonates with my view of professional and adult learning. The definition identifies change as an outcome of learning and importantly for me, focuses on the individual learner and their increased capacity and ability to participate or engage and belong or contribute in a social / professional context (Andrew et al., 2009).

This concept of learning reflects my belief of professional and adult learning in that there is an expectation of active participation; the learner is not a passive recipient of knowledge and the recognition of learning contributing to the creation of, in the case of my study, a professional identity. Given the focus on learning with and from others, the importance of participation is the essential element identified as necessary for learning to happen in Lave and Wenger’s work in contrast to the more commonly assumed transmission of information by an ‘expert’, resulting in a change in understanding or thinking within the student (Salomon and Perkins, 1998). The transmission model of learning in my opinion perceives the student as a passive recipient of information and does not support the concept of the adult learners identifying their own learning needs while also failing to recognise the complexity of nursing knowledge. Effective and safe nursing practice is I would argue, more than knowledge and skills attainment, it requires the ability to function and work within complex teams and organisations while maintaining evolving and changing relationships. I suggest that potentially, if nursing student learning is integrated within the clinical experience and engagement with a community of practice, students become more capable, skilled and develop their professional identity as they acquire for example the subtle aspects of nursing such as, the

language, gestures and practice of the established clinical team (Lave and Wenger, 1991). There are a number of central assumptions associated with the learning theory suggested by Lave and Wenger (1991) that I found relevant to clinical learning and the influence of others that aligned to my research question, such as;

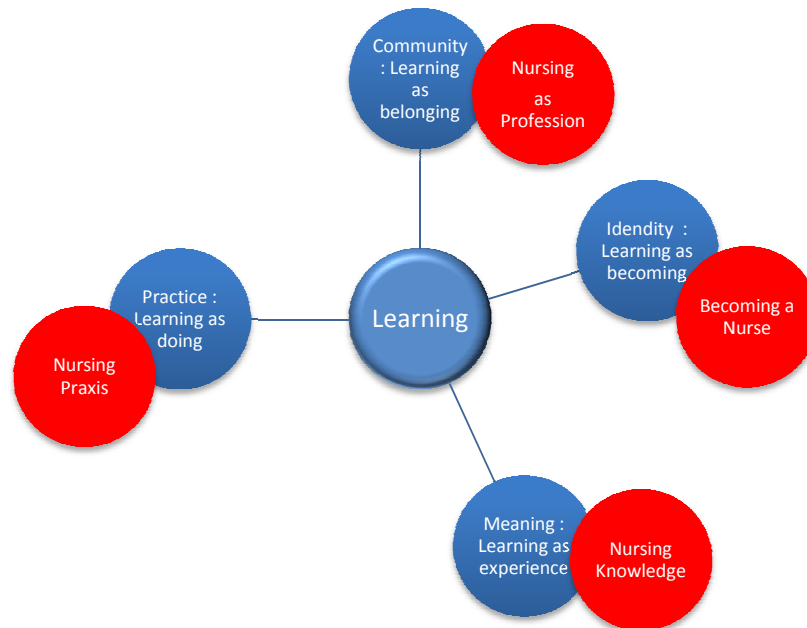
- A recognition of the known complexities of real life (Lave and Wenger, 1991)
- The importance of learning by doing (Lave and Wenger 1991, 1998)
- Mutual engagement, a joint enterprise and a shared repertoire (Wenger, 1998, p. 152)

In using the term 'influence' of registered nurses in the clinical environment in my research question, I align this term to Wenger's (1998) claim that views learning primarily as social participation. As a learning theory, social learning theory has in my opinion components that resonate well with professional and clinical learning (Thrysoe et al., 2010). **Diagram two** on the next page is an adaption of that proposed by Wenger (1998) where the four interrelated components of social theory of learning are identified. My modification identifies in the red circles where I believe there is congruence with the themes of nursing I identified earlier in this chapter (page 15). I have taken this approach in order to develop a framework by applying an established theory and aligning it to the categories I identified as a result of my early study. Lave and Wenger (1991, 1998) presented and detailed the concepts of situated learning, legitimate peripheral participation and communities of practice as interrelated elements of a coherent theory (Yandell and Turvey, 2007). In essence the central aspect of Lave and Wenger's work that is important to my research is the recognition that learning is the relationship between people and

'.... is more than simply acquiring knowledge, it is about identity change'

(Cox, 2005, p. 530)

Diagram Two – Components of a social theory of learning related to my identified themes of nursing practice



Adapted from Wenger (1998, p. 5)

Wenger (1998) suggested that the concept of legitimate peripheral participation provides three distinct aspects of allowing newcomers (students for the purpose of my research) to join a community of practice;

- 1 - Enabling newcomers to enter the world of the old-timer,
- 2 - Engage in progressive and increasingly complex activities and
- 3 - Support the development of the newcomer's identity as a member of the community.

The stance I took in framing my research approach is that the learning experienced by nursing students within the clinical placement element of their programme is social in context and that the learning which is gained in the clinical environment is facilitated by the experiences undertaken while interacting and participating within the communities of practice which exist within clinical teams.

From my review of the selected literature and policy documents, I established that

standards for nurse education, learning and assessment are set by the professional and regulatory body for nursing and midwifery in the U.K. While these standards are represented within approved education institutions and their validated curricula, I would argue that professional standards or competence are mediated and experienced by learners in the day-to-day clinical work of clinical teams (Eagan and Jaye, 2009). This aspect of clinical nurse education is key since, I suggest that while education planners might design a programme to meet a regulator's syllabus or education standards/competencies they cannot design learning. This view was supported by Wenger (1998) who claimed that learning, '.... belongs to the realm of experience and practice' and happens '... design or no design' (p.225)

Earlier in this chapter (page 25) I discussed the development of a competence and standards approach to nurse education in an attempt to support the preparation of newly qualified nurses who could demonstrate fitness for practice. Associated with this focus on developing clinical nursing performance should be a recognition that learning in the clinical environment is situated and context-specific.

The perspective of situated learning has relevance to the view of competence supported by the NMC, in that knowledge, skills and understanding are understood to be gained in practice which should be viewed as a whole (Lave and Wenger, 1991). This perspective on effective learning requiring an appreciation and engagement with the totality of practice and presents a more 'holistic' view of the learning experience and if achieved does, I believe more closely align an approach to learning that reflects the NMC definition of competence (Salomon and Perkins, 1998)

Communities of Practice : a framework to understand clinical learning

The theory of communities of practice provides a useful framework in which to understand the learning environment which nursing students experience while on clinical placements. A community of practice was identified as existing when a group of individuals engaged in a process of collective learning to achieve a common endeavour (Cox, 2005). It may be the case that nursing students become transient or temporary members of an established community of practice or equally, that when a nursing student is allocated to a clinical team a new community of practice is established around the student in supporting their learning for the time they are allocated to that team. It was identified that in some groups, individuals are core members while others are more at the margins (Cox, 2005). The current nursing curriculum requirements where learners are required to rotate through a range of clinical environments to gain a wide clinical experience may have a significant negative impact on a student's ability to develop relationships with 'old timers' and the transient nature of the student placement in the clinical environment may prevent any opportunity for engagement with the established team or community of practice.

Cox (2005) provided a useful critique of the development of communities of practice theory and concluded after his review of four seminal works that the ambiguity of the term 'community' and the resultant term 'communities of practice' should be seen as a strength. Cox (2005) argues that the,

'.... longevity and fecundity of the concept [communities of practice] may precisely lie in the ambiguity, enabling it to be appropriated in different ways' (p. 532)

Cox (2005) identified the development of the theory of communities of practice and how the concepts have been developed and taken into the fields of organisational development and noted the shift away from the original concept to be applied within organisations as a way of providing informal networks and structures to

support learning. It was also noted that the 'community' was now used to represent global collectives, for example, teachers as a community of practice, incorporating the body of knowledge and practice of an entire professional group. While this use of the theory may be of value, in the context of my research I am interpreting the original concepts that focused on the relationship between the newcomer and the 'old timers' within established, discreet communities of practice. The domain of a community of practice is central in creating an identity and focus of the community and the need for members to have a shared competence or skill and knowledge set which separates them from other groups or people. This view resonates well with the concept of the creation of nursing craft or practitioner knowledge which is founded on experience and passed on to others in the clinical setting (Perry, 2009). While the community of practice concept has a strong focus on sharing and facilitating skills and knowledge, the aspect of the community of practice assessing and making decisions on a student's competence changes in my opinion the nature of the relationship between student and the established community of practice.

The experiences reported by students in the literature (Orland-Barak and Wilhelem, 2005, Levett-Jones and Lathlean, 2008) identify the impact on learning when students do not feel welcomed or engaged within existing clinical teams, highlighting the potential importance and impact of students being actively involved within established communities of practice. Given the consistent theme emerging from the literature relating to student reactions to not feeling included in clinical teams and being socially isolated (Earnshaw, 1995, Cope et al., 2000, Donaldson and Carter, 2005, Orland-Barak and Wilhelem, 2005, Levett-Jones and Lathlean, 2008, Christiansen and Bell, 2010) the use of a community of practice concept is valuable in that the approach stresses the need for nursing students' to experience participation and collaboration with clinical teams to learn in the clinical

environment (Andrew et al., 2008).

Learning to 'fit in' : legitimate peripheral participation

The focus on identity creation and development is also key to my area of study in relation to my research question concern with 'becoming a professional'.

It is clear from my earlier discussion relating to the desire to revise nurse education to support greater levels of preparation for the 'real world' that a competence and strong professional skills element would be reflected in any proposed new standards. It may well be that acceptance into a community of practice is predicated on the ability of a nursing student to demonstrate that they are gaining the required skills and abilities needed for the group. There is a potentially negative aspect to the concept of students needing to be accepted by established clinical teams. In their study examining nursing students' experiences of belonging in the clinical environment, Levett-Jones and Lathlean (2009) reported the experiences of their participants learning not to 'rock the boat' when on placement. Levett-Jones and Lathlean (2009) interviewed 18 students, 12 from Australia and six from the UK. In the cross national case study Levett-Jones and Lathlean (2009) identified belongingness, conformity and compliance as central aspects of their participants' experience of learning in the clinical environment. Of key importance to understanding the student experience were participant descriptions of how they adopted or adapted to the clinical teams values and norms they were working with. The student participants claimed they did not challenge since they believed by complying they would improve their acceptance and inclusion by the nursing staff. Levett-Jones and Lathlean (2009) expressed concern for the need to support learners to be empowered and be able to challenge and speak out against poor nursing care and develop their own confidence as registered nurses. In a later study with thirteen UK nursing students,

it was reported that when students needed to 'speak up', they chose to 'exit or voice' (Bradbury-Jones et al., 2010, Bradbury-Jones et al., 2011). This study concluded that,

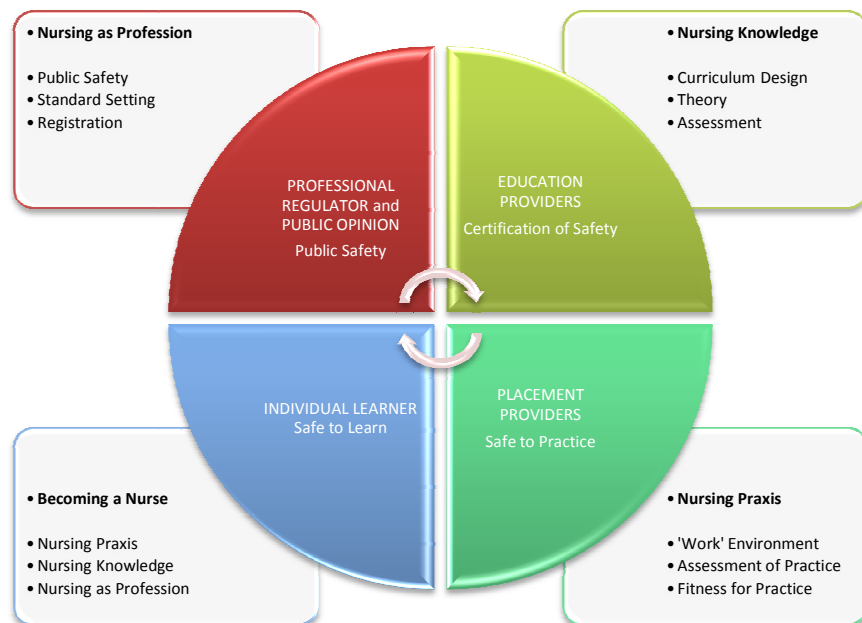
'.... students are often silenced in clinical practice' (p.628)

and the researchers discussed the need to give nursing students a 'voice' and strategies to raise concerns about poor patient care.

Earlier in this chapter I wrote about the complex nature of nursing (page 24) which is compounded from a learners perspective by the expressed need of students to accept and adopt established team routines and practice in order to be accepted into the clinical group. Practitioner knowledge presents a challenge in trying to 'pass it on' given that it may be unrecognised by practitioners and is often context specific and related to the area of care in that team (Perry, 2009). Communities of practice develop specific routines; vocabulary and documentation for example, to reflect the specific domain of the community and access to this knowledge may require engagement and interaction with the clinical team.

Diagram three on the next page, provides my conceptualisation of the key influencing and interrelated factors that are relevant to my research. **Diagram three** identifies the relationship between the professional regulator in terms of protecting the public through standard setting and registration. The role of education providers in implementing professional standards through curriculum development and certification of having reached the standard required for entry to the register. The clinical environment is represented as providing the opportunity to experience nursing practice with the associated certification of safe and professional standards of care. While **diagram three** separates out nursing knowledge and praxis I acknowledge that in providing nursing care, clinicians draw on theory and knowledge to inform practice and practice experience equally creates nursing knowledge.

Diagram Three – Contemporary UK nurse education – key elements identified in chapter one



Summary

This introductory chapter sought to provide the reader with the background knowledge and information relating to contemporary nurse education in the UK. The key issues of concern about the appropriate preparation of nurses to provide effective, safe and compassionate care were discussed. The development of the current approaches to education were set within the historical time line from 1986 with the introduction of *Project 2000* to the implementation of the new all graduate preparation that is due to commence in September 2011 with a requirement for all courses to be offered at degree level only from September 2013. Specific focus was made of the phenomenon of learning in a clinical environment with a discussion of the issues related to competence assessment and learning from others as highly relevant to my area of research. This chapter was intended to demonstrate and convey the complex and interrelated nature of clinical learning for nursing students in the UK and **diagram three** was developed to provide a visual representation of the interrelated nature of the delivery relationships involved in supporting and providing nurse education. The development of diagram three was intended as a way of describing and understanding the complex, interrelated and 'messy situation' (Robson, 2002) of current UK nurse education provision.

The next chapter explores and critiques the relevant literature applied to inform my research study and draws on **diagram three** to provide the structure for the chapter, which is presented in four sections; nursing praxis, nursing knowledge, becoming a nurse and nursing as profession.

Chapter 2 – Literature Review

Introduction

Chapter one provided the context and influences on the development of my research question and drew on the literature that informed my early thinking. This chapter focuses more specifically on the literature that has informed my understanding of the issues relating to my research question,

Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?

and influenced my choice of research methods while also providing the structure and focus for my interview and focus group questions. This chapter is structured using the four categories of, nursing praxis, nursing knowledge, becoming a nurse and nursing as profession which were developed and discussed in chapter one.

Search Strategy

I initially started with a broad search strategy using a range of key words including for example; competence, clinical learning, clinical education, assessing nurses, nursing student experiences, nursing skills that I entered into the online bibliographies. The main bibliographies I accessed and used were, CINAHL, ERIC, PubMed, ProQuest and the British Nursing Index (BNI).

After my initial key term searches, I used the reference lists of the articles I read to provide another additional source of potential relevant material. My search process was an iterative one and I returned to search and review the literature as my research question was refined and developed. I also returned to the literature to identify new material that was published over the time of my study.

Setting Inclusion and Exclusion Criteria

As a result of my search strategy, I identified a range of literature spanning the range of years from the 1970s to current time, across a number of countries and

different professions. To focus my reading in relation to the potential relevance to UK nursing, I limited the age span generally to cover from 1989 (the introduction of *Project 2000*) to the current day.

I identified a preference for research undertaken in the UK to reflect the specific policy and structural approaches adopted. I did however, recognise potential similarities with the Australian nurse education system, reflected in a number of research papers. Owing to the significant differences in the US and Canadian health care and nurse education systems I did not include papers from those countries save for one paper (Perry, 2009). While focusing on nurse education I did review papers from other clinical disciplines, mainly medicine and physiotherapy.

Learning in the clinical environment

Having conducted a literature search, I identified the articles that were specifically related to the student experience of learning in the clinical environment and the role of others in teaching. I then created a table to identify the results and themes emerging from the literature (**please see Appendix One – page 186**). I also recorded the research methods applied and the scale and range of the studies to gain an understanding of the types of research undertaken and potential approaches to inform my own work.

The literature supports the importance attached to the clinical environment in enabling learning for nursing students' and the potential of effective clinical learning on allowing nursing students to gain and develop fundamental nursing skills and attributes (Scholes et al., 2004, Pollard, 2006, Mallik and McGowan, 2007, Myall et al., 2008). There is support for the view of the clinical environment as more than a workplace and recognition that clinical placements provide an opportunity *for* learning rather than solely the arena to demonstrate and apply

previously gained, classroom knowledge and skills (Lave and Wenger, 1991, Andrews and Wallis, 1999). I consider this stance to be a subtle but important distinction because this position requires a focus on the existence of practice knowledge and the need for teaching and learning to happen in the clinical environment.

Orland-Barak and Wilhelem (2005) argued that in disciplines such as nursing, students had to master the ability to translate and apply subject knowledge acquired in the classroom into the situated context of clinical practice. This perspective is important in acknowledging that nursing knowledge and theory must be applied in the context of nursing praxis. This stance while recognising that knowledge can be applied to practice also needs to recognise the knowledge and learning that is created in and from practice, what I described earlier as, learning as experience.

If this is the case, and the knowledge available to nursing students in the clinical environment is often tacit and therefore hidden from the learner, as a researcher aiming to examine and understand how nursing students experience and achieve learning in the clinical environment, my data collection approach and methods need to be appropriate and effective in allowing me to gather what could be experiences that the participants had not previously considered and chapter three discusses and explains the data collection methods I decided to adopt.

Nursing praxis : learning as doing

This section of the literature review seeks to understand student experiences of the clinical learning environment from the perspective of 'learning as doing' and starts with a study undertaken by Pearcey and Elliott (2004) who explored nursing student impressions about clinical nursing in general. Pearcey and Elliott (2004) while examining student experiences from the perspective of trying to understand

why students left nursing courses still identified some key issues relating to the influence of the clinical environment on learning. The researchers used focus groups with 14 undergraduate final year nursing students. The participants were asked to identify positive and negative aspects of their clinical experiences. Of critical importance to my own research was the reported finding that students in the study claimed that their interest in finally becoming nurses was directly influenced by observation of registered nurses and nurses' attitudes towards them as students. This finding indicates that students are able to reflect on their learning in the clinical environment and can articulate the factors that impact on their motivation to become nurses. Three main themes influencing participant motivation to be a nurse emerged from the research;

- 1 - influence of ward culture,
- 2 - learning from the negative and
- 3 - mentors.

These three key themes identify the influence of, and the social nature of the clinical environment with the 'culture' created within individual clinical or ward areas, cited by the student participants' as a key influence on their impressions of what nursing was about. Linked to the clinical and ward culture are those who make up the environment, mentors and other staff. Of significant relevance to my study was the recognition by students that they were able to learn from negative experiences, which were potentially influenced by others in the clinical environment. While the concept of individuals learning from negative experiences feels counter intuitive, I was interested in the reporting that the participants had considered this and had insight of their experience to identify negative experiences as an influencing aspect on their learning. This finding reflects a range of other studies, which steer towards role models or mentorship as a key-influencing factor on the quality of students' clinical placement experience (Gray and Smith, 2000,

Myall et al., 2008, Ousey, 2009) and their development of confidence and preparation to become a registered nurse (Anderson and Kiger, 2008) and I would suggest, possibly on student learning.

From an International perspective, Nolan (1998) explored the experiences of learning in the clinical environment with six Australian nursing students. Again, reflecting the later work by Pearcey and Elliott (2004) the student participants in Nolan's (1998) study highlighted the importance of clinical staff support and the participants' need to feel part of the clinical team was seen as an important component of their ability to learn. The study identified three key student-feeling themes;

- 1 - 'I don't belong',
- 2 - 'doing and practising: progress at last' and
- 3 - 'Transitions in thinking'.

Nolan (1998) argued that students needed to make difficult adjustments to move from a university environment which promotes 'thinking' to the clinical placement area where the focus of learning was very much on 'doing' (p.623). This finding echoes my earlier point that there may be a failure to recognise that the clinical environment provides opportunities for learning by 'doing' and as a result learners may fail to value this aspect of clinical experience. Nolan (1998) went further in stressing that clinical staff who are unsupportive of student learning could have a detrimental impact on learning opportunities even when appropriate clinical experience is available to the student. This is a significant point and extremely relevant to my study.

However, the three key themes identified indicate that the students in the study (Nolan, 1998) did progress from a sense of not belonging to making progress and identified transitions in their thinking. It remains possible therefore that while participants did not identify engagement with a community of practice, their

experience of 'working' with clinical staff may well have provided the students with the knowledge and skills they needed to learn through 'doing'. This experience of peripheral participation may have allowed the participants to develop strategies to overcome any barriers to learning in the clinical environment. Nolan's overall conclusion was that while the study identified on going issues with supporting learning in the clinical environment, the recognition of the social element in learning,

'.... serves to remind all nurses of the importance they play in the learning process' (Nolan, 1998, p. 622).

While Nolan's (1998) study was undertaken in Australia, the experience of the participants in relation to clinical learning would suggest that my area of enquiry is potentially linked to the practice of nursing rather than a locally determined educational policy.

In a later study, Edmond (2001) identified a range of exacerbating factors impacting on the quality of clinical education such as the unavailability of mentors and resources to support students and a general lack of a true collaborative relationship between education providers and clinical facilities. Edmond (2001) described clinically based learning and skills development at the time as '.... clinical education by default' (p. 251).

Edmond's (2001) argument is of concern given the issues in relation to public safety and a need by the health care industry for newly qualified nurses who can 'hit the ground running' (Greenwood, 2000) and are 'work ready' (Solvoll and Heggen, 2010). Edmond's findings highlight the risk when clinicians fail to recognise the learning opportunities available to students in the clinical environment resulting in a possible student experience of 'doing' rather than 'learning as doing'.

The issue of lack of time to support learning was evident in the responses received

by Pulsford et al (2002) to their questionnaire to 400 mentors. From the 198 returned questionnaires from participants the key blockers identified by mentors in their responses to providing learning support to nursing students' were; time to undertake the mentor role, lack of management support, lack of information and support from the education provider, difficult to use and apply assessment documents and unmotivated students. Of particular interest in this work was that 60% of the respondents were noted as having been mentors for over five years. Given the respondents assumed level of clinical ability and mentoring skill, it is notable that this experienced cohort of mentors were identifying a lack of dedicated time as a barrier to effective clinical learning. The results from the Pulsford et al. (2002) study indicate that time needs to be identified to support clinical learning and that effective mentorship does not happen when provided solely as part of the clinical role, where no attempt is made to facilitate learning and the learner is simply 'working alongside' their mentor.

The earlier discussion about the influence of others on learning in Nolan's (1998) research was further supported by a later study undertaken by O'Callaghan and Slevin (2003). In their study, O'Callaghan and Slevin (2003) provided a useful contrast in perspective in that they examined the experiences of registered nurses who were supporting learning rather than focusing on student experiences. The study identified that, in the clinical environment there was a,

'.... lack of clinical teaching and an emphasis on work rather than learning'

O'Callaghan and Slevin (2003, p. 123).

This finding identifies that the focus of the clinical environment may not be on identifying or facilitating learning opportunities, but on exposing learners to the 'real world' with the assumption that this is sufficient to allow nursing students to gain the experience and skills they require. The potential challenge for nursing students may well be how to turn 'work' into 'learning'.

In their study exploring the experience of 29 undergraduate Australian nursing students, Newton et al. (2009) identified three key themes relating to clinical learning experiences based on interviews with the participants. The three themes were

- 1 – creating learning opportunities,
- 2 – gaining independence, and
- 3 – becoming part of the team

Interestingly, the researchers (Newton et al., 2009a, Newton et al., 2009b)(Newton et al., 2009) identified generational tensions between registered nurses and students and explained the problem of differing beliefs, expectations and needs across traditionalists and baby boomers (who were predominantly the registered nurses) and generation Y (born 1970s to mid 1990s) nursing students. The themes again reflect earlier studies in identifying the key role permanent team members play in creating learning opportunities for students, the need for students to be supported and allowed to ‘become’ independent and assume the role of nurse and the social component of nursing and the need to be welcomed and accepted into the team or community of practice. The researchers made the recommendation for educators to better prepare learners for the complexities of the clinical learning environment by raising student awareness of the social, cultural and political aspects.

Nursing knowledge : learning as experience

The previous section of this chapter examined the student experience of learning in the clinical environment. This section builds on the student experience of learning by exploring the qualities and abilities that constitute and ‘make’ a good nurse.

Girot (1993b) interviewed ten experienced U.K. ward sisters about their

experiences of teaching and assessing nursing students and the qualities they felt were necessary in demonstrating suitability to be a nurse. Each of the ward sisters described their own experiences of working with and assessing nursing students. The findings of Girot's (1993b) phenomenological study concluded that the characteristics of competence had 'trust' by the senior nurses in the students as a central component. Trust was represented as students knowing their own limitations, not being over confident and therefore could be trusted to act in a safe way. In her study, Girot (1993b) also noted that a caring and patient focused attitude combined with good communication skills were cited as important components of competence by the ward sisters. It was also noted in the study that the ward sisters acknowledged the difficulty in measuring attitudes as an example of the challenges staff faced when teaching and assessing clinical performance. The research while now over seventeen years old, raises the issue of the potentially subjective nature of clinical teaching and assessment. The ward sisters in the Girot (1993b) study perceived competence to be mainly a safe and non risk-taking approach to practice. This view of learning could potentially be in conflict with a graduate philosophy of education that may seek to encourage new ways of thinking and risk taking. Interestingly and importantly, Girot (1993b) did not identify how the ward staff knew that they could 'trust' a student. From my review of Girot's (1993b) work I believe the ward sister participants were drawing on their own tacit knowledge and applying their confidence in a student's safe performance as a proxy indicator of competence.

This focus on safety in Girot's (1993b) study is also reflected in the outcomes of a much later study by Ramritu and Barnard (2001). The researchers in this Australian study took a more targeted and personal approach than Girot (1993b) in the form of interviews with six newly qualified nurses. Adopting a phenomenological research approach, the study's aim was to understand the

experiences of competence of new nurse graduates (Ramritu and Barnard, 2001). The study (Ramritu and Barnard, 2001) identified eight conceptions of competence based on the interview comments made by the newly qualified nurses that they described as:

- safe practice
- limited independence
- utilization of resources
- management of time and workload
- ethical practice
- performance of clinical skills knowledge and finally,
- evolving

The area of competence relating to safety to practice is frequently cited by regulatory bodies and is perceived as a key function of protecting the public from dangerous nursing care. The concept of competence as evolving is an interesting one and reflects the notion of competence as a fluid and changing quality and may well reflect the realisation by the newly qualified participants that they had further skill and knowledge development to complete and that competence is not fixed in time. What remains elusive from the literature is the identification of the components of nursing knowledge and skills that constitute nursing and ultimately a 'good' and 'safe' nurse.

Good nursing care: more than clinical skills ?

Studies have indicated the main areas where employers felt that nursing students lacked ability, such as: numeracy; time management; prioritization; critical thinking; clinical skills; and an ability to consult appropriately with colleagues (Greenwood, 2000). The focus on professional abilities beyond 'hands on' skills was also reflected by Ryan (2001) who suggested that the role of the modern nursing

programme was to ensure that students gained the skills of critical-analysis, problem-solving, decision-making, reflective skills and abilities essential to the art and science of nursing. The ability to engage in critical-analysis, problem solving and reflection, for example, are complex skills and may prove to be difficult to demonstrate and articulate in the clinical environment to learners. It is equally important to note that the areas of deficiency identified by Greenwood in 2000 are all mentioned in the four new competence domains of; professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team working introduced by the Nursing and Midwifery Council (NMC, 2010b).

In her longitudinal study, Spouse (2001b) aimed to explore the influences and factors which determined pre-registration nursing students' development of professional knowledge during their clinical placements. This work has strong relevance to my area of study since it explored student perspectives on how they gained professional knowledge. The study identified two specific knowledge types, the first was concerned with the technical ability to inform nursing care which was differentiated from the second type of knowledge concerned with professional role or how to 'be' a nurse.

Usefully the research identified seven categories of knowledge;

- Relating to patients and their relatives
- Developing technical knowledge
- Learning to bundle activities of nursing together
- Developing craft knowledge
- Relating to and functioning within a clinical team
- Managing feelings and emotions (their own and those of patients and relatives)

- Developing the essence of nursing, which promotes therapeutic action.

(Spouse, 2001b, p. 150)

I was interested to note from this study the specific identification of relating to patients and relatives, managing feeling and emotions and relating to and functioning within a clinical team. These three areas of development appeared to go beyond the traditional skills and 'doing' aspects of nursing care identified as nursing students' experience in earlier studies. In these three areas there is acknowledgement of the social aspects to nursing care and a recognition of the complex nature of nursing care. Of key relevance to my research were the results reported by Spouse (2001b) of the need for nursing students to be able to relate to and function within a clinical team to learn effectively.

In their novel study, Orland-Barak and Wilhelm (2005) reviewed the written stories of 25 nursing students which described how the students learned the practice of nursing. Interestingly Orland-Barak and Wilhelm (2005) identified that the student participants focused their writings on technical descriptions of their caring behaviours rather than highlighting the actual caring skills they had gained. The researchers argue that the student focus on descriptive procedural view of their nursing ability indicated an immature development of the participants' learning in clinical practice. Orland-Barak and Wilhelm (2005) stressed in their discussion that,

'.... rich content of practice *alone* does not yield rich content of learning' (p.462).

This key statement reflects the important consideration that it is insufficient to simply place nursing students within the clinical environment and assume and expect that 'learning' will happen automatically as a result of the student having access and exposure to the experience in the clinical environment. Orland-Barak and Wilhelm (2005) highlighted that in situations where nursing students were not supported with effective learning strategies, they failed to move beyond replicating

what they saw on placement and viewed their nursing practice as a series of skills without appreciating the complex and higher level skills and thinking required by expert nurses. This opinion supports my earlier argument that if the complexity of nursing care is not made explicit and visible to students they will fail to be able to recognise, appreciate and demonstrate the level of nursing care required when they register. The final and very relevant conclusion of the Orland-Barak and Wilhelm (2005) study argued that learning in the clinical environment needed to shift from 'replicating performances' to have a much greater focus on caring for others.

Pearcey and Draper (2008) examined student experiences of clinical learning using semi-structured interviews in their study with 12 first year nursing students. As first year students, the participants in this study generally would have had limited exposure to and experience of the clinical environment and nursing. The study is also very relevant to my area of work due to the focus on clinical learning. From an analysis of the participant transcripts, Pearcey and Draper (2008) identified what the student participants considered to be key nursing values and priorities. The areas identified were: paperwork; communication; tasks; routines; and caring.

The student participants articulated a concern that the reality of nursing as they had experienced it did not reflect their personal values or expectations of what nursing would be. The participants spoke about a perceived lack of caring by nurses for patients and a prioritisation and pre occupation with 'paper work'. The students also described the focus on tasks and needing to 'get things done quickly'. If the students perceptions of nurses as uncaring and concerned with 'paper work' was echoed by patients, the reference in chapter one to the media portrayal of nurses as 'too posh to wash' (BBC, 2004) may be well deserved. The researchers concluded that the students in their study suffered from a realisation

shock of the realities of nursing and that there was a failure to make a distinction between the clinical environment as a 'learning environment' and as a 'nursing' environment by clinical staff and educators (Pearcey and Draper, 2008)

Again, the findings from this study reflect the earlier literature discussed and identify the failure to recognise that the clinical environment was and should also be a learning environment (Orland-Barak and Wilhelm, 2005). The current U.K. model of education where theory is provided within the university setting and students are then exposed to clinical care, creates a situation where learners have knowledge in waiting which needs to be supported by clinical staff to become knowledge in use (Spouse, 2001a). The distinction between differing types of knowledge is discussed later in this chapter (page 71).

Of interest to my research was the perception by students that nurses lacked a caring attitude to patients and focused on tasks. Were this perception to be the case it would appear that the nurses this particular group of students were working with were failing to reflect the nursing role identified by the Nursing and Midwifery Council (2010b).

In establishing the future education standards for nurses the Nursing and Midwifery Council in their Standards for pre-registration nursing education (NMC, 2010b) have adopted the following definition of a nurse as;

'... a professional person achieving a competent standard of practice at first cycle level following successful completion of an approved academic and practical course. The nurse is a safe, caring and competent decision maker willing to accept personal and professional accountability for his/her actions and continuous learning. The nurse practices within a statutory framework and code of ethics delivering nursing practice (care) that is appropriately based on research, evidence and critical thinking that effectively responds to the needs of individual client (patients) and diverse populations' (p. 11).

The definition refers to a 'competent standard of practice', 'competent decision maker' while also acting as a 'professional person' who is professionally and personally accountable for their actions and omissions with the ability to provide safe, caring and research based care.

The revised standards set out the framework and regulatory requirements for all U.K. pre-registration nursing awards. As identified earlier in this section, the NMC outcomes are set within a competency framework consisting of four domains; professional values, communication and interpersonal skills, nursing practice and decision making and finally leadership, management and team working. While the four domains provide a framework, in my opinion they remain broad and unspecific and may lack the detail and standardisation that Bradshaw (2000) argued for.

Bradshaw's (2000) view was strongly criticised at the time by Kitson (2001) who feared that Bradshaw's proposed approach would result in a behaviourist model of nursing competencies as a means to,

'.... bring back the certainty and order of a lost age' (p.92).

While the debate and contrasting positions between Bradshaw (2000) and Kitson (2001) is now 10 years old, It has been argued that previously and currently, nursing students lack sound clinical skills and are passing courses without the required abilities (Fitzpatrick et al., 1993, Girot, 1993a, Bradshaw, 2000a). There is a significant risk that mentors will continue to view the clinical environment as just that, a working environment failing to recognise the need to also view the clinical environment as a learning environment if alternative approaches to learning are not promoted (Newton et al., 2009).

The variations in clinical learning and assessment of ability are I argue, due to a lack of little or no examination of what the learning outcomes of a pre-registration nursing programme should. In particular the lack of identification of the actual skill sets and abilities beyond simple lists of clinical tasks (While, 1994). The

development of the Essential Skills Clusters by the NMC (NMC, 2007) may go some way in addressing this concern, however a recent survey of mentors identifying their reluctance to fail students they believe should not pass suggests otherwise (Gainsbury, 2010).

The first section of this chapter examined the broad context of the clinical environment in terms of supporting clinical learning. The second section looked at defining what the learning outcomes for nurses in the clinical environment needed to be. This next section will review the literature relating to what is known about the impact and role of others in influencing nursing student learning in the clinical environment.

Becoming a nurse : learning as becoming

My research question reflects the concept of 'becoming a professional' and Lave and Wenger (1991) argued that learning is integrated with practice and that through social engagement with a community of practitioners students or new members of the community become increasingly competent in their identity as practitioners.

This section examines the role of others in supporting nursing student learning in the clinical environment. Baillie (1993) took a phenomenological approach in interviewing eight nursing students to identify the factors which affected their learning while on a clinical placement. The outcome of the study was that the role of the mentor was identified as crucial for learning. The students identified mentor knowledge and attitude towards students, their professionalism, in particular communication skills as essential for effective mentorship.

Earnshaw (1995) adopted a different approach to Baillie (1993) when using a questionnaire to survey 19 students about their experiences of mentoring. Overall the students found mentoring to be a valid means of learning support, in particular

and importantly, during the early stages of their programme. Of particular interest to my study, the participants noted that mentors provided a socialising role, passing on,

‘.... norms of behaviour and ward routines’ (p.274)

Role models and the identification of mentors as role models is recognised in the literature as a strong influence on nursing students’ learning in the clinical environment (Gray and Smith, 2000). The student perspective on what was needed from a mentor was explored by Gray and Smith (2000) in their longitudinal study within a grounded theory methodology. Gray and Smith (2000) reviewed the changing perspectives nursing students had of mentorship over the course of their studies. The key elements to emerge from the work were that a good mentor,

‘.... is a good role model as they are professional, organised, caring and self confident.’ (p.1546)

The student participants in the Gray and Smith (2000) study also expressed the belief that mentors supported learning and without them their learning would be reduced. The research did not identify how learning was supported or the ways in which role models supported learning.

In her study examining nursing students’ conceptions of nursing at the start of their studies and how their views influenced their development, Spouse (2000) reported that the images of nursing that students held were significant in motivating them to remain on their course or to leave when the perceived reality of nursing did not match the image held by the student.

Cope et al. (2000) undertook interviews with 30 students representing 11 who completed their nursing course based on an older curriculum and 19 from a revised and newer ‘Project 2000’ course. The study is of value to my research since the researchers used cognitive apprenticeship and communities of practice frameworks to situate their work. In reporting the results, the researchers noted

that there was striking similarity between the two groups in how they described their placement experiences. The central themes emerging from the research were: joining the community of practice; the contextualisation of learning; and the support of learning in practice.

The theme of joining a community of practice was described by the participants as being accepted as part of the team. Interestingly, the researchers made a distinction between social acceptance by the team with greater responsibility given to the student and clinical acceptance over time as the student demonstrated competence and an increase in professional trust. This finding presents an important distinction between two components of social acceptance and clinical / professional recognition that learners need to achieve.

Finally, support of learning was described as fitting into a cognitive apprenticeship model. The researchers identified that the learners were coached by mentors who provided support that was progressively reduced as each student demonstrated increasing ability and competence. One key aspect of student feeling supported and safe was the knowledge that a mentor would be present and ready to become involved in care should anything unexpected happen. The work undertaken by Cope et al. (2000) demonstrates that students are able to articulate their experiences of clinical learning and the themes drawn out from the interviews, again support the literature in identifying the social nature of clinical learning and the role played by members of the clinical team or community of practice in scaffolding and supporting learning. The research also reinforces the importance of social and professional acceptance into the placement team in creating a sense of belonging that students identified as key to successful and effective learning.

The role of the mentor was also recognised by Lloyd Jones et al. (2001) as key in enabling preregistration nursing and midwifery students to gain maximum experience from their clinical placements and often the element identified as

supporting learning was the frequency of contact the learners had with their mentor. The result that learning was supported by the frequency of contact with mentors indicates, I would suggest, that some element of social interaction and contact is required for learning in the clinical environment to take place.

Scholes et al. (2004) undertook a comprehensive and wide ranging review of Nurse Education Partnerships in the U.K. The study reviewed 16 different provider sites and triangulated their findings with site visits, document and curriculum analysis, interviews and surveys. One student questionnaire captured 760 responses and overall the work was able to provide a coherent and 'joined up' overview of a range of elements within nursing programmes, from recruitment and retention to placement learning. A key message contained within the executive summary of the report was that clinical learning for nursing students was,

'.... affected by poor quality role modelling, support and supervision'

(Scholes et al., 2004, p. 18)

The work undertaken by Donaldson and Carter (2005) who used a grounded theory methodology to look at the value of role modelling in teaching and learning within the clinical environment further builds on the social aspect of clinical learning and teaching. The researchers undertook focus groups with 42 U.K. degree and diploma level nursing students. The results concluded that all participants could give examples of 'good' and 'bad' role models and identified role modelling as,

'.... extremely important within the clinical learning environment' (p. 355).

Earlier it was argued that nurses might have difficulty in articulating and making the nursing role, knowledge and professional attitudes visible and accessible to students. The role of exemplary nurses acting as role models in supporting effective clinical learning could prove to be a possible means of facilitating effective clinical learning. In relation to the wider clinical team, importantly

exceptional nurse role models were found to affirm the value of other colleagues (Donaldson and Carter, 2005).

Recognising the central role that mentors are expected to play in the teaching and assessment of nursing students, the study undertaken by Donaldson and Carter (2005) provides a useful insight into the influence of role modelling on student learning. In the context of nurse education, there may be many potential role models influencing student learning which goes beyond just their one mentor. However, given the specific role that mentors are required to play in the teaching and assessing, mentors are recognised in the literature as needing to be effective role models. There is a possible tension with the NMC requirements that states, '.... at least 40% of the student's time must be spent being supervised (directly or indirectly) by a mentor' (NMC, 2008b) (p. 31)

The minimum 40 per cent supervision time may be taken as the level of contact required and learners may be left for a significant amount of their time without the support and guidance of their mentor.

In their grounded theory research, Donaldson and Carter (2005) used focus groups to interview 42 adult branch nursing students across all three years of their study to discuss their perceptions of role modelling. The findings claimed that students had experienced and could differentiate between 'good' and 'bad' clinical role models. Participants in Donaldson and Carter's (2005) study considered effective role models to also be 'good nurses' (p. 355). The students expressed the view that they expected to learn from role models by copying their behaviour and attitudes. It is interesting that the student participants identified possible learning would result from copying the good nurses, which is worrying if this copying of behaviours and attitudes is not selective. There is clearly a risk if this approach were the true model of learning to be a professional nurse. Such an unquestioning form of learning would allow poor and unsafe practice to be

propagated and replicated. While the study did not identify whether role models were specifically mentors the research outcomes are equally applicable given the role that mentors are expected to fulfill.

Pollard et al. (2006) conducted a review of the literature relating to clinical learning and concluded that student mentorship as an identified method of supporting learning was 'fraught with difficulties' (p.317). A number of potential and actual obstacles were noted by Pollard et al. (2006) in stopping mentors from acting as effective educators such as; time constraints on mentors, workloads, role conflict, skill mix and staff shortages.

The conclusions published by Pollard et al. (2006) were reflected and supported by a detailed and extensive study that was undertaken during 2003 to 2006 by Mallik and McGowan (2007). In their paper the researchers outlined the results from the first year of a scoping exercise that was examining the nature of practice education in five health professions including nursing. Applying a case study approach to understanding nurse practice education the researchers concluded that there was evidence across the UK of good working relationships and sharing of responsibility for placement assessment between education and health providers. The key negative issues identified related to variation across the UK with an,

'.... inadequate supply of qualified mentors; formal recognition of the mentor role; and lack of knowledge of the relative impact of the differing mentor preparation programmes' (Mallik and McGowan, 2007, p. 52).

While these findings (Mallik and McGowan, 2007) sit within an historical context and are superseded by the NMC publication and implementation of their *Standards to support learning and assessment in practice* (NMC, 2008b) the literature indicates that for a period of time between the early 1990s and 2009 there was at best, a variability and quality of clinical learning support and

experience for nursing students (Scholes et al., 2004, Pollard, 2006, Lewin, 2007, Mallik and McGowan, 2007) that could have contributed to the issues and concerns previously raised relating to fitness to practice and preparation of nurses at the point of first registration.

Following a study using questionnaires and telephone interviews with over 200 mentors and mentees, Bray and Nettleton (2007) described on-going tensions for mentors between their dual roles as mentor and assessor. The researchers noted that mentors described a range of roles including;

‘.... teaching, becoming a friend, communicating appropriately, being an example of how to be a nurse, listening and encouraging reflection, supporting and passing on clinical skills’ (Bray and Nettleton, 2007, p. 852).

As with many other studies, Bray and Nettleton (2007) did not explore the ‘how’, for example, there was no discussion or exploration as to mentor understanding of the ways they passed on clinical or reflection skills. The central outcome of the study, which was the role conflict mentors experience as both facilitators of learning and assessors is a potential on-going problem given the current and longer term intended practice-learning model. This area of concern reflects the earlier debate relating to the ‘failure to fail’ where it was identified that mentors had difficulty in failing students who were unable to demonstrate safe care (Duffy, 2003).

A later study by Perry (2009) took a different approach to exploring role modelling by interviewing and observing eight Canadian registered nurses who were identified as exemplary by their colleagues. Findings from the research identified that exemplary role models; attend to the little things, made connections, model and affirm others. Of key significance to my study was the recognition that exemplary nurses were able to teach both clinical skills but more importantly, ‘.... the often tacit or unspoken aspects of exemplary nursing care, their craft

knowledge' (Perry, 2009, p. 40).

The literature reviewed is generally supportive of the mentor role in nurse education and effective mentors or good role models are cited by learners as having a positive effect on learning and enjoyment of clinical placements (Lloyd Jones et al., 2001, Wood, 2005, Myall et al., 2008). Perry (2009) argues that role modeling,

'.... presents as a strategy that can tap hidden craft knowledge making it more accessible to learners' (p.38).

She further adds that there is limited research to date exploring how role modelling by exemplary nurses can be used to facilitate learning in the clinical environment (Perry, 2009). **Table two** provides a summary and overview of the key elements taken from the literature that identify the elements of effective mentorship and equally what are considered blocks to effective mentoring.

Table Two - Factors enabling or blocking effective mentorship

Enabling	Blocking
<ul style="list-style-type: none"> • mentor knowledge and attitude towards students • professionalism • communication skills Baillie (1993) <p>mentors who are;</p> <ul style="list-style-type: none"> • professional • organised • caring and self confident Gray and Smith (2000) <ul style="list-style-type: none"> • mentor would be present and ready to become involved in care should anything unexpected happen Cope et al (2000) <ul style="list-style-type: none"> • effective role models are also 'good nurses' Donaldson and Carter (2005) <ul style="list-style-type: none"> • teaching • becoming a friend • communicating appropriately • being an example of how to be a nurse • listening and encouraging reflection, 	<ul style="list-style-type: none"> • poor quality role modelling, • poor levels of support and supervision Scholes et al (2004) <ul style="list-style-type: none"> • time constraints on mentors, • workloads, • role conflict, • skill mix and staff shortages Pollard et al (2006) <ul style="list-style-type: none"> • inadequate supply of qualified mentors • formal recognition of the mentor role Mallik and McGowan (2007)

- supporting and passing on clinical skills
Bray and Nettleton (2007)
- attend to the little things
- made connections
- model and affirm others
Perry (2009)

Earlier in chapter one, I highlighted that mentorship has featured in nursing courses in a formal and recognised way since 2000, with the professional regulator providing specific standards for the mentor role in their document *Standards for the Preparation of Teachers of Nursing, Midwifery and Health Visiting* (UKCC, 2000). Despite the establishment of the mentor role, there is clearly a mismatch between the claims made of effective mentor roles and the concerns raised about student ability on completion of programmes. However, the literature fails to identify how role models can influence learning and the approaches students take to learn from role models. This gap in the knowledge is one of the key influences on my selection of research question; ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?*** and is a central focus of my research.

Role models in clinical learning

Modelling was identified as one of six components required for effective cognitive apprenticeship (Woolley and Jarvis, 2007). Woolley and Jarvis (2007) applied principles of cognitive apprenticeship to develop learning resources to support nursing students gain effective clinical skills. Cognitive apprenticeship is a relevant concept for my area of study in that as an instructional model, it seeks to build upon the traditional apprenticeship method of teaching where the apprentice observes a master craftsperson and then replicates the action. The significant extra aspect of cognitive apprenticeship approach is recognition that there is additional thinking and knowledge that is not observable when completing a task

and in a cognitive apprenticeship approach the teacher needs to make the thinking associated with the task visible to the learner (Woolley and Jarvis, 2007). I believe there is alignment with social learning and cognitive apprenticeship in that the importance of others in facilitating learning is recognised while emphasising that experienced staff or 'old timers' need to be aware of the need to articulate and make their knowledge available to learners. In the earlier section (*page 67*) exploring the role of mentors I suggested that potentially mentors and registered nurses were not supervising nursing students for a variety of reasons from workload pressures, lack of staff and confusion about the mentor role. I would suggest that at times when nursing students are unsupported there is a risk that they will simply observe skills and nursing care but not have access to this 'hidden thinking', the tacit or craft knowledge and this superficial level of skills and care delivery may have given rise to the concerns around fitness for practice (Amin and Roberts, 2008).

In discussing the challenging of capturing teachers' professional knowledge, I found similarities with the experiences of nurses and teachers and the problem identified by Loughran et al. (2003) in,

'.... seeing the knowledge in practice' (p.853)

Loughran et al. (2003) argued that the social culture of teaching did not encourage teachers to discuss their practice and attempt to make explicit their tacit knowledge and indeed teachers did not have the language to adequately express this level of practice knowledge. Usefully the authors described, knowledge for practice, knowledge in practice and knowledge of practice (Loughran et al., 2003). I would suggest that for nursing students', knowledge *for* practice is provided through the teaching provided in the classroom and knowledge *in* practice is possibly gained by students during their placement experience. The knowledge *of* practice is that which experienced nurses can potentially provide to learners if they

have sufficient contact with students but may struggle to articulate if, like teachers, they,

‘ do not necessarily take their own knowledge seriously, leaving it mostly untapped and known only to she/he who holds it’ (Loughran et al., 2003, p. 853)

Central to my area of research is the reliance of the cognitive apprenticeship approach on,

‘.... social processes that incorporate active participation within culturally organised environments and activities’ (Woolley and Jarvis, 2007, p. 75)

Modelling was described as the first element to support learning followed by coaching, scaffolding, articulation, reflection and exploration. In their study which examined the effectiveness of using these six components to support the teaching and learning of clinical skills, Woolley and Jarvis (2007) concluded that there are significant resource and organisation demands on providing a comprehensive curriculum approach to preparing nursing students to gain clinical skills using the approach they tested.

One argument in support of role modelling as an effective and desirable learning approach is that observation of others’ behaviours and actions allows an individual to acquire ways and patterns of behaving in a much more efficient and safer way than purely by chance or trial and error (Bandura, 1977). Observation is identified as an element of a community of practice in relation to member engagement. It was recognised that within communities of practice members engage in active and passive engagement (Lave and Wenger, 1991). During passive elements of engagement it is argued that a member observes the interactions of others (Andrew et al., 2008). Of even more importance from a professional perspective is the fundamental premise that an observer’s behaviour may be modified as a consequence of witnessing and observing others (Bandura, 1986). Given the concerns raised about the lack of suitability of newly registered nurses both in

terms of clinical skills and professional attitudes, exposure to effective and appropriate role models may prove a useful means of facilitating learning about how to 'be' a nurse, the elements of the profession which are based on and reliant on accessing, acquiring and developing tacit knowledge.

In contrast to the earlier suggestion by Wenger (1998) that learning happens regardless of design (p. 40); Woolley and Jarvis (2007) reported that successful skills development within a clinical environment could be designed and structured using a cognitive apprenticeship approach. Of key importance to nursing is the argument that learners develop conceptual understanding by participating in 'real life' situations and problems while learning with and from experts (Woolley and Jarvis, 2007). The recognition of the importance of learning with and from provides a platform for supporting clinically based nurse education but does require structured and explicit roles for registered nurses and a need to understand how 'experts' can effectively facilitate learning. This approach while very structured may provide a framework to negotiate the tension noted by Lave and Wenger (1991) of the continuity-displacement contradiction, where learners need to engage with experienced staff to gain knowledge and skills, while also developing their own professional identity, practice and contribution to the clinical team.

Nursing as profession : learning as belonging

Having explored in the last section the influence of mentors and role models on learning in the clinical environment, the focus will now shift to look at the experiences of students and in particular the impact of 'belonging' on learning. I would argue that nursing and learning to 'be' a nurse in the clinical environment and becoming a professional are contextually situated within the social worlds of health care (Cope et al., 2000). As new entrants to the world of nursing care, nursing students are exposed to the reality of health care and the associated

unpredictable nature of the clinical environment.

In her longitudinal study, Spouse (1998) followed seven pre-registration nursing degree students during their clinical placements. The study is of particular relevance to my own work since the student participants were questioned about their experiences of clinical learning and the factors that influenced their professional development. Spouse (1998) made use of a number of data collection methods including, student documentary evidence, observations of and interviews with the student participants.

The study was of additional value to me since Spouse (1998) reported the key finding arising from this research as the role of the mentor in providing sponsorship. Spouse (1998) argued that without sponsorship a nursing student lacks identity within the community of practice and risks becoming alienated. One of the main conclusions drawn from her study was that,

‘.... without effective sponsorship by a mentor, legitimate peripheral participation in any form of meaningful activity was impossible and consequently students found it difficult to engage in clinical activities or to learn’ (Spouse, 1998, p. 347)

To be successful while on placement and ultimately learn and be certified as competent a student must be able to establish and maintain effective social interactions which result in acceptance into the nursing team and provide access to learning (Spouse, 2001a). Equally the role of nursing and providing care is a relational phenomenon in that to provide care someone must be in receipt of that care (Solvoll and Heggen, 2010). In her paper exploring the supervisory relationships between nursing students and clinical staff, Spouse (1998) took a sociocultural stance to her research and drew on the concepts of the zone of proximal development and scaffolding, arguing for the relevance to professional education away from the traditional application of these concepts to early childhood learning. The argument presented by Spouse (1998) was that nursing

students needed to be supported in making connections between 'formal' knowledge gained in the classroom and the 'informal' knowledge gained in the clinical environment.

Levett-Jones and Lathlean (2008) described a study undertaken with Australian and U.K. third year nursing students exploring the impact and influence that belongingness had on their ability to learn effectively in the clinical environment. Their key finding from the research was that belongingness was highly influential on student participants' motivation and capacity to engage in clinical learning opportunities. The researchers described 'belongingness' as related to the degree that an individual felt;

'.... (a) secure, accepted, included and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group'

(Levett-Jones and Lathlean, 2008, p. 104)

This description of the factors needed to have a sense of belonging could be facilitated, I argue within a community of practice or community of clinical practice, which are discussed in the next section.

Of key relevance to my research was the reporting that the registered nurses students worked with on a daily basis,

'.... were the single most important influence on their sense of belonging and learning' (Levett-Jones and Lathlean, 2008, p. 107).

This finding highlights the value that students placed on having daily and on going contact with registered nurses, but possibly not specifically a mentor. While the study identified the impact that students reported this contact had on their sense of belonging, it was not clear if the 'belonging' contributed to student learning. Equally the paper did not identify how this contact influenced or supported learning. I would argue that potentially having daily contact with registered nurses

provided an opportunity for students to observe and model staff, which students perceived as supporting and enabling their learning. I would question however, whether effective learning could be supported solely through contact with a registered nurse without identified and negotiated learning objectives. Without this negotiated approach there is potential to worsen what Lave and Wenger (1991) describe as the power relations between masters and apprentices.

I found the paper written by Eagan and Jaye (2009) to be very relevant to my area of study. Eagan and Jaye (2009) adopted the specific term 'communities of clinical practice' (CoCP) to refer to clinical teams where clinical students joined a team to gain learning. The defining and unique aspect of a CoCP in comparison to any other COP is that the CoCPs comprise of staff that,

'.... congregate around individual patients for the purpose of caring for their health' (Eagan and Jaye, 2009, p. 112)

This view of clinical teams aligns with my personal view of nursing care and reflects the NMC standards in placing the individual patient at the centre of professional health care activity while also placing the patient as the focus of student learning.

To engage in an inbound trajectory newcomers need to be recognised as potential members of the CoCP and welcomed and supported by the existing and established CoCP members demonstrating to the newcomer that,

'.... they have a right to be there and a purpose' (Eagan and Jaye, 2009, p. 116)

Eagan and Jaye (2009) discussed the negative experiences of learners who were not welcomed to the CoCP and describe the potential for clinical students to have an experience where they are;

'..... belittled, pushed into taking responsibility inappropriately, observe inappropriate practice, disagree but are unable to say' (p.116)

and how such experiences could lead clinical students to question continuing on their course of study. The experiences highlighted by Eagan and Jaye (2009) serve as a reminder that the terms 'community' and 'practice' are not exclusively friendly or harmonious concepts (Cox, 2005).

White (2010) used social-cultural theory to support her critique of nursing curricula supporting and building on the earlier work by Spouse (1998). The outcome of her critique was that applying socio-cultural perspectives into nursing curricula would improve the clinical experience of nursing students. It was argued this would be achieved by forcing a reappraisal of the meaning of learning, supporting clinical experience in a community of practice through sponsorship.

The role of others in supporting learning was also reported by Roberts (2009a) who undertook an ethnographic study to examine the value of peer learning to pre-registration nursing students and if nursing students learnt from each other, and if so when and where this learning took place. The recommendation from the research was a need to recognise the value and influence of friendship on learning in the clinical environment. Roberts (2009) argued that nursing students develop their own 'parallel community' as a result of existing on the edge of the established community of practice (the established clinical team). For the participants in Roberts (2009) study, the experience of being part of a 'parallel community' produced the emotion or feeling for the students' of 'being in the same boat'. This isolation and feeling of being an 'outsider' from the established team of staff drew the students' together to find emotional support, friendship and learning from each other.

A related study explored peer learning and also supported the importance of social engagement with the clinical team (Christiansen and Bell, 2010). In their study exploring the potential of peer learning partnerships, Christiansen and Bell (2010) identified that new nursing students experienced feelings of social isolation. This

theme was reported following descriptions from participants of the challenges of being a student in a working environment. In the very early stages of their course or when on a new placement the theme of social and learning isolation was noted by the researchers (Christiansen and Bell, 2010).

This section of chapter two has identified the role played by registered nurses and others as role models on supporting learning and the associated challenges to effective mentorship. The role of mentors in the UK, experienced nurses with responsibility for student learning was explored and the historical lack of clarity around the role and potential blocks to supporting students such as work loads and lack of agreed learning approaches to learning were examined. I suggested that the social aspect of nursing care was a central element of learning to 'be' a nurse and that the complexity of contemporary nursing practice required more complex learning approaches than apprentice or observational learning.

Summary

This chapter presented a critique of the specific literature I identified as relevant and meeting my selection criteria; to informing my understanding of the research question; ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

Reflecting the complexity of the area of study, I drew on a range of literature to support my understanding of the existing knowledge. Starting with the learner experience of the clinical environment, the key aspects identified in the literature presented were; the need for nursing students to understand the ward culture; learning from negative experiences; the importance of mentors and others in supporting their learning; and a desire to be accepted as part of the clinical team. Equally important, the clinical environment was also regarded as a place of work rather than learning and this had the potential to have a negative impact on

learning; with students perceiving the established clinical staff as too busy to support learning with a focus on 'getting the work done' the priority.

The next section of this chapter focused on literature that explored the core skills and abilities that nursing students needed on completion of their studies. Within the literature reviewed, there was a strong focus and requirement on safe practice with an expectation of nursing students not working outside their ability or skill level. Specific abilities and expectations of newly qualified nurses were also identified as necessary by employers, such as time management, problem solving and communication skills.

There was then a shift in focus to examine the role of others in supporting clinical learning, focusing specifically on role models. The literature identified that students could describe and identify 'good' and 'bad' nurses and a central element to effective learning by students in the clinical environment was a registered nurse's ability to make explicit and describe their craft or tacit knowledge, their knowledge *of practice* to students.

Building on the earlier sections, the literature relating to how a sense of belonging influenced learning in the clinical environment and the importance of being accepted and valued by clinical teams was a significant aspect of students' ability to learn.

Prior to undertaking my research, the existing literature was supportive of the importance of the clinical environment as enabling learning to happen (Scholes et al, 2004, Pollard et al., 2006, Mallik and McGowan, 2007). Existing studies indicated that learning was supported and enabled by established members of clinical teams and mentors in particular (Myall et al., 2008). Barriers to learning were also identified such as claims by registered nurses to having insufficient time to facilitate learning (Pollard et al., 2006). Positive role models appeared to be an influence and motivation to learn for students (Perry, 2009). There is recognition in

the literature that much of nursing practice is reflected in craft knowledge and the difficulties in articulating what constitutes nursing remains unanswered with a continued focus on defining skills (Giot, 1993, Ramritu and Barnard, 2001, Ryan 2001, Spouse 2001b).

Existing research studies were frequently based on semi structured interviews or focus groups with nursing students and/or mentors and registered nurses. In the majority of studies reviewed the numbers of participants ranged from eight to 54 (**appendix one – page 186**). While the current literature is extensive there was a gap in terms of exploring, explaining and understanding *how* nursing students learn in the clinical environment. I wanted to build upon previous work and understand individual nursing student experiences of learning in the clinical environment with a specific focus on how their learning took place. Building on the strong support for the role of registered nurses in supporting learning, the next chapter details the research methodology and approach I took to examine the gap in the existing knowledge I identified.

Chapter 3 - Research Methods

Introduction

This chapter details the research question and aims. The focus then shifts to discuss the choice of method and strategy, which was case study (Yin, 2009), the ethical considerations and how I undertook my pilot study. I then describe how the student interviews and later registered nurses focus group data collection were conducted. The chapter then concludes with my strategy for and analysis of the data.

The Research Question

The research question I explored was: ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

The research question underwent regular updating and revision during my period of study. The development and refinement of the question was led by the literature and my growing awareness and identification of a gap in the literature in relation to how others in the clinical environment influenced nursing students' learning (page 70). My working research question was focused on interaction between nursing students and others in the clinical environment and formed the basis of my interviews with the student participants. However, on reviewing the early analysis of the student transcripts, I became aware of the emerging themes that aligned more closely to influences of registered nurses and mentors on learning. As a result of this insight I revised my working question and decided to undertake additional data collection with registered nurses through a focus group. The addition of a focus group was intended to triangulate (Gerrish and Lacey, 2006) my interview data. The focus group participants were selected from a different site to the student group in an attempt to increase the potential transferability of the

eventual findings.

This question was examined through a number of specific research aims. Recognising my stance as discussed in chapter one (page 38) in terms of the situated and social components of learning, the question allowed me to explore and understand learning from the perspective of the individual learner experience. I identified and mapped the four social learning areas to my research question to demonstrate how social learning theory informs my research as follows:

Becoming a professional [Identity]: what is the influence of registered nurses [Community] on nursing students' learning [Meaning] in the clinical environment [Practice] ?

I have taken the definitions provided by Wenger (1998) in defining the four components of a social theory of learning;

- 'Identity' provides a means of talking about how learning changes the individual and provides 'personal histories' (p. 5) of becoming,
- 'Community' (p. 5) defines the social structures that learning happens within and where a learner's knowledge and skill may be valued and recognised,
- 'Practice' (p. 5) describes the shared experiences and memory of individuals combined with the differing perspectives that support and drive collective working and finally,
- 'Meaning' (p. 5) is the term used to explain how, through sharing and discussing their developing ability and skill, individuals make sense of the meaning of their experience.

Research Aims

The students in my sample were asked to;

- Recall and describe in their experience, the factors that influenced their learning in the clinical environment,

- Identify from their experience the influence of others in their learning e.g. clinical staff and mentors, and
- Describe how they identified the learning and experience they needed to gain from the clinical environment.

The research aims were designed to record the participants' experience and were structured to focus on exploring and describing the actual learning experience rather than describing a situation or what happens during a clinical placement. To provide an additional level of understanding and perspective, a focus group was facilitated with eight registered nurses undertaking an N.M.C. approved mentor preparation course, to explore their experiences and role in supporting clinical learning. A critique of the effectiveness of this approach is provided later in this chapter (page 97).

Appraisal of Research Method Taken

The research approach I have adopted is qualitative and was chosen since the methods associated with a qualitative study reflect an interpretivist tradition. An interpretive approach is appropriate for my area of study as a methodology that, '.... seeks to understand human behaviour and the social processes that we engage in' and allows 'interpretation in natural settings'

(Gerrish and Lacey, 2006, p. 158)

The definition provided by Gerrish and Lacey (2006) reflects my approach and perspective in relation to the research question, which was concerned with the social aspects of learning that I wanted to understand from the context of the learner experience. Leininger (1985) also described an interpretive approach as gaining the full description and interpretation of what is being investigated from the participants viewpoint.

I chose to apply Bryman's (2004) key features of qualitative research as a critique

of my method to assure myself that my approach was appropriate. I considered my area of study and method to be effective since I could reflect the three areas identified, which are;

1 - The inductive relationship between research and theory, my research question was structured to generate theory rather than test a hypothesis and therefore reflected an inductive approach and style,

2 - Has a stronger focus (than the natural sciences and positivism) on the ways individuals make sense of the social world. As I stated earlier, my research question was strongly focused on the experience of learners and I wanted to understand learning in the clinical environment from the learners perspective and finally,

3 - Qualitative approaches seek to understand phenomenon as experienced by individuals themselves, this key aspect of qualitative methodology influenced my research design and methods choices.

The interpretative approach most importantly, recognises that difference exists at an individual, social and cultural level and as such there can be no single interpretation, truth or meaning applied to an experience (Gerrish and Lacey, 2006)

In considering my choices of qualitative research strategies I undertook a case study approach (Yin, 2009). The type of case study design I used was based on Yin's (2009) 'embedded single-case design' (p. 50). The embedded single-case is based on the context of learning in the clinical environment with the nursing students and the experienced nurses representing the two embedded unit of analysis. The next section of this chapter discusses case study design.

Rationale for Case Study

Aware that my research focus was on understanding the individual experiences of final year nursing students I identified that I would need a research strategy that allowed me to capture the unique experiences of individual student participants.

Having considered the approaches available to me such as ethnography and participatory action research for example, I chose a case study design for a number of key reasons. Rowley (2002) argued that case studies support detailed study of areas of investigation needing to answer the 'how' and 'why' questions. In considering my research question, I identified the 'how' as, *how* does interaction with registered nurses in the clinical environment influence nursing students' learning? Equally relevant was my overall concern of *how* can nursing students' be best supported to learn effectively in the clinical environment through the influence of registered nurses.

In terms of the 'why' I considered a number of possible questions informed by the current literature, such as for example, *why* do nursing students have differing experiences of learning in the clinical environment ?, *why* do mentors find it difficult to 'fail' students ? and *why* do students feel unappreciated and unwelcome in clinical teams ?

Johnson and Christensen (2008) described case study research simply as,

".... research that provides a detailed account and analysis of one or more cases"
(p.406)

In analysing my interview and focus group transcripts I found that my work did provide me with a number of detailed and personal accounts of learning in the clinical environment with and from others.

While frequently cited (Robson, 2002, Gerrish and Lacey, 2006, Anthony and Jack, 2009) I found the following quotation a strong influence on my decision to make use of case study design for my study. Yin (2003) described case study as

an approach that,

‘... investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident’ (p.13).

In chapter one, **diagram three** (page 44) summarised the complex and interdependent nature of clinical learning as I understood it; providing the context for my study and the contemporary nature of my work with the new NMC (2010b) education standards and clinical competency domains (page 25).

This definition by Yin (2003) appealed to me since it reflected my understanding of the area of enquiry I was interested in and was attractive because of the emphasis on ‘real life context’ and the recognition that the topic under investigation is closely linked and related to the context it is experienced in. I recognised the close association between the experience of learning and the context of the clinical environment and potential influence of others on that learning. I considered that case study offered me the flexible approach I needed to research in an area where boundaries were not clearly identified when exploring and examining the experiences and perspectives on learning from students’ and registered nurses (Gerrish and Lacey, 2006).

In a later publication, Yin (2009) stated that a case study approach was appropriate when a researcher wanted to,

‘..... understand a real-life phenomenon in depth’ (p.18).

Both the quotations by Johnson and Christensen (2008) and Yin (2009) share the ‘detailed account’ and ‘in depth’ focus of case studies, reflecting the qualitative tradition of understanding the richness termed as a ‘thick description’ (Geertz, 2000) to capture the detail of specific experiences under investigation. I anticipated that by gaining a detailed description of individual and personal experiences I would gain an insight to the complex nature of learning in the clinical environment that I discussed in chapter one and summarised in **Diagram three**

(page 44).

By contrast, Yin argues, case study embraces the complexity of multiple variables and potentially uses a wide range of methods and sources of evidence in order to shed light on the phenomenon being investigated. However, a case study is not without a theoretical basis and Yin (2003) contends that case study, “benefits from the prior development of theoretical propositions to guide data collection and analysis” (p. 14).

My development of the research question, interview and focus group structure and framework for data analysis was informed by social learning theory and the current relevant literature.

A case study approach was also claimed to, ‘.... show a strong sense of time and place; they represent a commitment to the overwhelming significance of localized experience’ (Yandell and Turvey, 2007, p. 81).

The ability of a case study to represent a unified view of the phenomenon under study supported the view of learning proposed by Lave and Wenger (1991), which they argued, ‘... must be understood with respect to practice as a whole’ (p. 114).

My use of a case study approach values and stresses that the experiences of those I interviewed are unique to them and should be understood from their perspective. Case study allowed me to recognise the individual experiences and value them in their own right, allowed for participant engagement, was flexible, valued holism within context and acknowledged the complex phenomenon I was studying. Yin (2009) provided a comprehensive and useful account of how case study design could demonstrate effective compliance with the four design tests; construct validity, internal validity, external validity and reliability. **Table three** on the next page, provides an overview of the four tests, the case study tactic

suggested by Yin (2009) to demonstrate compliance with the test and where the tactic was implemented in my research. I applied the guidance provided by Yin (2009) when planning and structuring my methods to ensure that my research had an appropriate and robust framework and structure. The use of the four tactics would also provide a structure allowing me to achieve and demonstrate, credibility, transferability and dependability (Koch, 1994) in my work.

Table Three - Case study tactics for four design tests
adapted from Yin (2009, p. 41)

Test	Case Study Tactic	Where evidenced in this thesis
Construct Validity	<ul style="list-style-type: none"> • use multiple sources of evidence • establish chain of evidence • have key informants review draft case study report 	<p>Interviews with students and focus group with experienced nurses</p> <p>Analysis / Results reported using actual transcript details</p> <p>Informants given copies of transcript and results for comment and review</p>
Internal Validity	<ul style="list-style-type: none"> • do pattern matching • do explanation building • address rival explanations • use logic models 	<p>The first stage of data analysis (Appendix Ten - page 196)</p> <p>In chapter 4</p> <p>In chapter 4</p>
External Validity	<ul style="list-style-type: none"> • use theory in single-case studies 	Social theory informing research
Reliability	<ul style="list-style-type: none"> • use case study protocol • develop case study data base 	<p>Yin's (2009)</p> <p>transcripts produced and direct quotes from transcripts used in data analysis and available for scrutiny</p>

The four tactics detailed by Yin (2009) allowed me to design and plan my case study approach provided my protocol and allowed me to later demonstrate within my research; construct validity, internal validity, external validity and reliability. The tactic suggested for internal validity provided me with my protocol for analysis. The tactics (Yin, 2009) cannot however, mitigate for the external factors I was unable to control associated with the particular location and group of students I interviewed.

Ethical Considerations

The ethical guidance and best practice standards provided by the Economic and Social Research Council (ESRC) and British Educational Research Association guidelines contained in the Revised Ethical Guidelines for Educational Research (BERA, 2004) were used to inform my research planning, structure of information sheets and consent forms and how I conducted the research interviews and focus group meeting.

Participation in the interviews was voluntary and participants self selected to be involved. Nursing student participants' and experienced nurses were recruited from two local Universities. I chose local universities to facilitate ease of travel and flexibility in arranging interview times to suit the participants. Given that all nursing and mentor preparation courses must meet the Nursing and Midwifery Council standards I did not identify an issue with researching using local education Institutions. I do not have any direct input to the student population at either university, as an educator or external examiner.

An application was made to The Open University, Human Participants and Materials Research Ethics Committee through their initial ***Human Participants & Materials Ethics Committee (HPMEC) Project Registration and Risk Checklist*** and at a later date I was required to submit a full ***Human participants and***

materials ethics committee (HPMEC) Pro forma.

The Human Participants and Materials Research Ethics Committee provided permission to proceed with my data collection (**please see appendix two – page 188**). I also submitted a research proposal and the Open University letter of approval to both the Universities I intended to use and their relevant research committees provided approval. I submitted a completed Data Protection Questionnaire for Students to The Open University Data Protection Coordinator and I have managed the collection and storage of the gathered information in compliance with the principles of the Data Protection Act 1998. The initial approach to the student cohort was by an email circulation sent via the nursing programme leader. **Appendix four – page 190** provides the content of the email. The email was designed to raise awareness of my research, my professional and study background and what would be involved in the interview process, allowing potential participants to make an informed decision about participating in the research. The cohort size of the group I approached was about 60 students. After the first week, four students emailed me to indicate that they were willing to participate in the study. I emailed each of the participants with a confirmation of the interview details and information about how the interview would be conducted (**Appendix five – page 191**) once a suitable day and time was identified. A second email reminder was sent by the course leader to all students in the cohort and a further three students contacted me indicating that they wished to be involved in the study. Thus participants self selected to participate and I considered the use of a group email as the most effective means of communication while the least intimidating method of raising awareness of my request. The greatest ethical concerns I had related to any disclosure or identification of unsafe or poor student support or patient safety. As the literature clearly identifies, the range of clinical learning experiences are wide and it is

possible that participants may identify examples of harassment or unsafe patient care in their discussion of experiences. I obtained from the university the relevant information and contact details relating to student support services. Had any participant discussed examples of clinical learning or express concerns that may require intervention and support I would have highlighted this at the end of the interview and offered the support information. There was also the risk that as self-selecting participants, a student participant may view the opportunity to complain or raise issues. There was also a risk that the student participants' may become upset or distressed during the interview and I needed to be aware of the possibility of having to conclude an interview early. In conclusion, no issues were raised during the student participant interviews. I felt that all participants were open and honest in their responses and while there was discussion about the challenges of learning and emotional feelings, for example,

‘... I definitely cried more in first year.... ‘ **P1**

no references were made to unsafe nursing care or inappropriate learning experiences. At the end of the interviews I sent a formal letter to all participants, thanking them for their participation (**Appendix four – page 189**) with the intention that this letter could be used as ‘evidence’ for inclusion in their student portfolios of learning.

Sampling for Interview and Focus Group Participants

The sampling method I chose was purposeful because I selected student participants who had knowledge about the area under study due to their experience. The identified sample group for the final research was made up of final year adult nursing students completing a three-year nursing degree course in the U.K. I selected final year students since they would have in my opinion the widest range of clinical experiences, having undergone and being about to

complete their three-year programme. Equally important, as this group of students are completing their study they should be developing their own professional identity as a result of their learning as discussed in **chapter one** (page 38). Five final year degree-nursing students from the same cohort were interviewed and all participants were female. I made initial contact with the final year nursing student sample population through their university email accounts. The message was sent by the university nursing programme leader (**Appendix four – page 189**).

The email communication was used as a cost effective and efficient means of contacting all students and provided an explanation and overview of my work, established an early relationship with potential participants, answered any questions potential participants may have had and prepared the interviewees for the interviews (Sorrell and Redmond, 1995). The use of email also protected the students' contact details since the initial email was sent directly from the university. I also provided the participants with a written information sheet of the key areas that would be discussed at the meeting (**Appendix five – page 191**). Given the nature of the interview format and the importance of establishing a safe and open forum for mutual sharing of opinions, ideas, impressions and experiences, it is clearly important that potential research subjects are fully aware of the research and what participation will involve. This information was provided from both an ethical perspective in ensuring that the students were fully aware of the research while also ensuring that the participants were willing to share their experiences and perspectives (Nolan, 1998).

Seven students offered to participate. However, two participants cancelled or did not attend at the agreed interview time. I made attempts to reschedule, however after the fifth interview was concluded, I reviewed the data I had gathered and decided not to continue to try and reschedule the final two interviews since I had

gathered a significant amount of information and did not want to reschedule for a third time in case the final two participants were now reluctant to be involved.

Focus Group Participants

Eight registered nurses participated in the focus group. **Table four** below, provides an overview of the key profile information gathered about the participants.

The group represented an experienced section of registered nurses with six of the group having seven or more year's experience. Half the group reported to have daily contact with nursing students, indicating that they had relevant experience of supporting learning in the clinical environment.

Table Four - Profile of the focus group participants

Years of Experience Since Registering	Under One Year	1-3 Years	4-6 Years	7 or more years
Number of Participants	-	2	-	6
Current Contact with Nursing Students	Daily	Weekly	Monthly	None
Number of Participants	4	3	1	-
Main Patient/Client Group	Adults	Mental Health	Children	Learning Disability
Number of Participants	8*	-	1	-
*One participant indicated two client groups				
Area of Current Work	Inpatient	Community		
Number of Participants	7	1		

I contacted the group as a cohort completing a mentor preparation course and their length of experience did make the group suitable and appropriate to explore the focus group questions I developed. The majority of the focus group

participants were currently working within a hospital setting looking after adults. The group was not representative of the range of working environments or client groups where nurses practice. While I would have preferred more representation from non-hospital nurses, I considered the sample to be legitimate since all participants were experienced registered nurses with on-going contact with nursing students and had completed their formal mentor preparation course at the time of the focus group taking place. There is scope however, for future research examining if there are differences in mentorship approaches between acute (hospital) based nursing and community (non hospital) clinical learning environments. The registered nurse group was selected from a different geographical area to the nursing student participants. I chose differing areas of practice to gain a wider range of practice experiences and as a result the student and nursing student group would not have had any contact with one another.

Interview Approach Taken

I chose to use an interview approach for the main study rather than questionnaires due to the often, poor response rate (Robson, 2002) and more importantly the inability of questionnaires to capture individual stories and experiences effectively (Gerrish and Lacey, 2006). The interview method allows for flexibility to explore in more detail and offers greater flexibility in questioning and I believe greater scope to understand the experience due to the less predetermined nature of the interview and the likely hood that participants may share and revel more in an interview than on a questionnaire (Sorrell and Redmond, 1995). I believe the greatest challenge for me as a researcher in adopting this particular data collection approach is the significant fact that I as the interviewer, will be the data collection instrument (Sorrell and Redmond, 1995). In choosing to use interviews as the source of data collection I was mindful that as the interviewer I would be acting as the instrument

for collecting the data (Rowley, 2002). Having reflected on my ability to effectively interview, I considered myself well placed to do this due to my knowledge of the student experience and my experience of interviewing and establishing and maintaining safe relationships with people as a result of my job role. I was aware of the importance of structuring my data collection and analysis within the case study tactic framework proposed by Yin (2009) (detailed on page 88 of this thesis) to mitigate for any bias that I may introduce during the analysis of results.

Interviewing is a well-established and appropriate approach within qualitative research design (Sorrell and Redmond, 1995) and aligns well with my perspective of the individualised nature of learning. Of equal importance is the alignment with essential features of socio-cultural perception of learning in viewing learning as participation in a community of practice and as dialogue. As a registered nurse I perceive myself as being able to relate within a social-cultural context to the participants while using dialogue to explore their experiences. Through interviewing I should be able to explore the experience of learning from the unique perspective of the interviewee. In their paper reviewing approaches to interview techniques, Sorrell and Redmond (1995) noted that there had been over the preceding decade a significant increase in the number of nursing focused research projects using interviews as a method of data collection. This finding by Sorrell and Redmond (1995) indicated to me that interviewing was an appropriate and acceptable data collection method for research undertaken within nursing.

In planning my research methods I have kept at the forefront of my planning the goal of recording faithful accounts from participants. In controlling the interviews I was aware of my role of researcher in needing to capture the experience or situation as it is understood by the participants (Carr, 2005). Through the process of describing their experiences of learning it was my intention to make, '.... the implicit more explicit' (Carr, 2005, p. 336).

Development of the Interview Questions

In developing the questions to use in the nursing student interviews and experienced nurse focus group, I used the literature reviewed to inform and develop the areas of questioning ***please refer to tables five and six*** (pages 96 and 100)

For the student interviews, I developed five main questions with an additional related sub question. The questions reflected three key themes that I wanted to understand the student lived experience of and ability to recall and describe; Profession, Learning and finally Interaction and Influence.

Table Three - Development of the student interview questions

Area of Enquiry	Interview Question	Relevant Literature
What is Nursing? (Profession) Rationale Were the student participants able to articulate their view of what nursing was and did they have the ability to describe good, safe nursing care?	1.0 Please describe what you consider makes a 'good nurse'? 1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ? 2.0 How did your view of what it means to be a good nurse develop during your experience on clinical placements ? 2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?	Gray and Smith (2000) Donaldson and Carter (2005) Pearcey and Draper (2008) Perry (2009) Spouse (2000)
Learning to be a nurse in the clinical environment (Learning) Rationale Were the student participants able to identify the specific elements of nursing care that they achieved in the clinical environment. Were they able to identify learning outcomes specific to clinical placements and how did they identify if they were making satisfactory progress	3.0 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ? 3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?	Spouse (2001b) Orland-Barak and Wilhelem (2005) Pearcey and Draper (2008) Duffy (2003)

Influence of Others in the Clinical Environment (Interaction and Influence) Rationale Were the student participants able to identify the influence and impact of others on their learning in the clinical environment.	4.0 Describe your experience and what it is like when working with a 'good nurse' during clinical placements	Baillie (1993) Cope et al. (2000) Gray and Smith (2000)
	4.1 Describe how working with a 'good nurse' on clinical placement influenced your learning	Woolley and Jarvis (2007) Perry (2009)
	5.0 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	Roberts (2009a) Christiansen and Bell (2010)
	5.1 Give an example of how others in the clinical environment have helped you to learn	Roberts (2010)

Testing the draft student interview questions

I made contact with a group of final year nursing students at a local university and they agreed to participate in a group discussion using my draft research questions as the focus of the meeting. I met with eight students and tested my draft interview questions. I also asked the group how they would feel about having an interview recorded and if that would dissuade them from participating. They all indicated that audio recording an interview was not perceived as a negative or something what would prevent them from volunteering. I made short notes on the group responses to my draft questions and the responses indicated that the participants understood the questions and the responses provided reflected my area of enquiry. I noted that the questions were long and detailed and as a result I decided to present the questions as a PowerPoint presentation on a laptop screen during the actual interviews to support recall of the questions by participants.

Focus Group Approach

After completing the student interviews and the initial coding of the transcripts, I became aware of the significant references that the student participants made to their mentors and registered nurses. I felt it was important to gain the perspective

and experiences of registered nurses to reflect and acknowledge the relationship and influence of nurses that the student participants were describing. For example, student participant one who described one of her mentors as,

‘... she was just really, really nice to the patients. I remember actually coming back home and being thinking that that’s the kind of nurse I would like to be’

I chose to adopt a focus group approach with registered nurses. I decided to undertake a focus group since there were logistical and time constraints on accessing individual registered nurses outside of their routine clinical working. The opportunity to facilitate a focus group allowed me to gather data from a number of registered nurses while causing minimum disruption to their time and allowed me to undertake the additional data collection within my planned timeframe. I considered a focus group an appropriate method of data collection because I was asking questions about experiences of supporting student learning and was not seeking to gather sensitive or personal information about the individual nurses.

The established cohort of registered nurses that participated in the focus group had shared experiences as nurses and had supported nursing students. I reasoned that a focus group method would gather relevant data based on their shared experience through group discussion as indicated in the definition of a focus group as,

‘.... a group interview centred on a specific topic and facilitated and coordinated by a moderator or facilitator - which seeks to generate primarily qualitative data by capitalising on the interaction that occurs within the group setting’

(Sim and Snell, 1996, p. 189).

I was mindful of the literature that suggested that nurses struggle to articulate their craft knowledge (Perry, 2009) and my intention was that the group discussion facilitated in a focus group would support an articulation of the participants experiences which they may not have formally considered or articulated

previously. My experience of conducting the focus group suggested that the registered nurses did contribute and develop responses to the questions, at times building on comments made by other members of the group. While the focus group transcript did capture a range of opinions and experiences, the perspectives were less personal than those provided in the student interviews. The depth of description of experience gathered in the student interviews was not as evident in the focus group. Focus group participants tended to give one-sentence answers, which were then picked up by others members of the group. While this ensured participation from all members of the group, the level of discussion was in my opinion limited. The approach did however, allow me to gather discussion and comments from eight registered nurses and the group discussed all the questions posed with all members contributing at different stages of the interview.

The focus group approach also reflected my perspective on social learning in the definition that a focus group,

‘.... taps into human tendencies. Attitudes and perceptions relating to concepts, products, services or programs are developed in part by interaction with other people. We are a product of our environment and are influenced by people around us’ (Kreuger, 1994, p. 10)

Reflecting my qualitative methodology, focus groups were seen as harnessing, ‘the interaction within a group to elicit rich experiential data’ (Asbury, 1995, p. 414). On reflection I felt that it was appropriate to collect data from a focus group of registered nurses and I have examples where different individuals in the group indicated their support either verbally or non-verbally to comments made. Often initial comments made were developed with further discussion from others. For example;

FG1 was describing how pressures of work impact on teaching

'It's from observing what their mentors are like, and if you've got a good mentor that's caring and takes time and does the teaching or whatever or if you've got a mentor that's under pressure and stressed and keeps brushing you off you know it does have an effect on the skills you're going to learn'

FG2 Interjected immediately – talking over the other speaker, saying;

FG2 *'But you can still be pressured but still and handle the students caringly'*

While **FG1** indicated her support for **FG2** saying 'yea ... yea' while **FG2** was speaking.

Table four details the focus group questions that were designed to reflect the student interview ones from the perspective of registered nurses.

Table Four - Development of the focus group questions

Theme	Focus Group Question	Relevant Literature
What is Nursing ? (Profession) Rationale Were the participants able to articulate their views of what nursing was based on their experience as registered nurses	1 - What does it mean to be a 'good nurse' ?	Perry (2009)
Learning to be a nurse in the clinical environment (Learning) Rationale Were the experienced nurses able to identify aspects of nursing care that they facilitated, the barriers to learning and ways they assessed effective learning.	2 - What elements of nursing care can't be taught or learnt in the classroom but can in the clinical environment? 3 - What stops students from learning effectively on placement ? 4 - How do you know that students are learning effectively when on a placement ?	Baillie (1993) Duffy (2003) Gainsbury (2010)
Influence of Registered Nurses in the Clinical Environment (Influence and Interaction) Rationale Were the experienced nurses able to describe how learning is achieved in the clinical environment and their influence on learning	5 - How do students learn to be 'good' nurses ? 6 - Based on your experience how do nursing students learn from you when on clinical placements ?	Woolley and Jarvis (2007)

Data Collection

The fieldwork was undertaken between October 2010 and January 2011. I decided to digitally record the interviews. My main reason for making a recording of each interview was to ensure I could engage with the participant during the interview without the need to continuously make a written record of the interview. The digital recording did also allow me to produce a full transcript of the interview and not risk losing any detail. There was a risk to recording the interviews due to potential participant anxiety about having the discussions recorded and the potential technical challenges of achieving a quality recording in busy environments. However, the use of a recording device did not prove to be an issue. I took a number of steps to reduce the possible negative impact of recording on participants by assuring that all recordings will be deleted following the study and no record will be maintained between the recording and the participant's actual name. Based on the positive experience detailed by Brown (2006) when she interviewed lecturer practitioners about their experiences supporting learning, I made notes directly after each interview, with the intention that they would act as additional prompts and ideas during the analysis of the data.

A marker identified each candidate (e.g. Participant 1) and the marker only identified records/recordings of the interviews. I maintained a separate record of the participant record and actual identifying name. This information was used to allow me to email the appropriate interview record back to each participant for review and checking. None of the student participants communicated the need for any changes to the transcripts.

Data Analysis

At the conclusion of my data collection I had a rich source of data in the form of individual transcripts from each student participant, which I had transcribed

verbatim. The focus group recording was also transcribed verbatim and provided a second source of data. The data were analysed using an inductive approach, reflecting the qualitative nature of the study (Miles and Huberman, 1994).

The findings from the individual interviews and focus group were identified from my analysis of the transcripts using open coding. Initially I listened repeatedly to each of the interview and focus group recordings to become very familiar with the content. The next stage of analysing the data was achieved by reviewing the transcribed participant interviews in three different ways/stages by;

- 1 – Student participant and each research question
- 2 – Social learning theme for each student, and
- 3 – The four NMC competency domains.

For stage one of my review of the participant transcripts, I separated out key comments against each of the interview questions (***please see appendix ten - page 196***) to look for trends and recurring themes that may have been evident. A key guiding principle I kept in mind while undertaking my analysis of the data was the need to describe and interpret human experience in credible and insightful ways (Gerrish and Lacey, 2006). To support an additional and differing perspective on the data, a second stage of review of the interview transcripts was completed by categorising the responses against the four elements of the social learning model I adopted. The third and final stage of analysis I applied was the new NMC competence domains (***appendix twelve – page 211***). **Table five** below provides an overview of the codes I used at each stage.

Table Five – Protocol for analysis - key words used to code interview transcripts

	<i>Stage One – Research Question</i>	<i>Stage Two – Social Learning Theory</i>	<i>Stage Three – Professional Regulator Framework</i>
	Profession	Becoming	Professional Values Nursing Practice and

Codes	Learning	Belonging	Decision Making
	Influence	Experience	Communication and Interpersonal Skills
	Interaction	Doing	Leadership, Management and Team Working

Table six provides a sample from three student interview transcripts of how I coded the data using the key words. For simplicity and presentation purposes, six coded examples are provided. However, when conducting the actual coding, I reviewed transcripts and coded each stage separately. There were examples of comments made by participants that were coded for more than one key word where the content reflected and captured different aspects of the research question. The presentation of an example and availability of the coding of the data is an important element in documenting and demonstrating the internal validity of my work and provides transparency to how as a researcher, I selected and made inference through my coding decisions.

Table Six – Example of coding student interview transcripts

<p>PARTICIPANT TWO (P2)</p> <p>Codes : Profession Learning Influence Interaction Belonging Caring</p> <p>Q1 - Please tell me what you consider makes a 'good nurse'?</p> <p>Erm ... I think the usual things which crops up is you have to care about what you do, erm communication is another one</p> <p>Researcher - When you say crops up ? is that the correct answer or is it what you genuinely believe ?</p> <p>No, that's what I think when people say erm..... a good nurse they care and that they want to help people and I know that is quite a cliché , wanting to help people, erm but I do agree with it</p> <p>Researcher - So the essence of a good nurse, the kind of nurse you would want to be would have to have a component of caring in it ?</p> <p>Yea..... erm..... I think, I was just going to say, I think some people have had that element and then not got bored with it but it starts to lack and that's when they stop becoming a good nurse and it becomes more of a job rather than something you want to be doing like yea that just becomes your role I think.....</p>

Researcher - Have you had experience of that, have you seen that with people you have worked with ?

I think erm good people I have worked with nurses that make people laugh as well, like you have that side to you as well or you can be, you can have a serious side to you as well and get everything done but you can also you don't just do your job make everyone I don't know how to put it, you're not just working you interact as well and then you just get the people who do the paperwork, give out the drugs and that's that and the patient contact becomes a lot less

Participant Four (P4)

Q1 - Please tell me what you consider makes a 'good nurse'?

Someone who cares and genuinely got into the profession to look after patients not for other reasons because it was easier or because it was the only thing they could do or they're very patient centred erm they have time to talk to the patients erm they want to be there.

Quite a lot of nurses on placement you think.... I really don't want to be here and you just think that's going to influence on their patient care ermtheirem ... is it empathetic towards the patients erm..... I suppose its that kind caring all those kind of words

Q 1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?

Erm I think quite a lot of them would be the same erm but in regard to ability I think you have to be erm quite confident I see that as an ability because to approach a patient to approach the families to approach students and people you have to be quite confident and have that confidence, that's quite I think quite an important ability I think the nurses that are good have ... they can separate professional from personal but they have this kind of like banter line where they use it to bring out peoples emotions and to get to what there feeling but though I think humour's a really good way to do it but you can quite easily stop if it gets too personal but patients that I have seen worked well with a nurse the nurse has that quality especially on my end of life oncology placement they I think they had to have that cause its quite a hard placement and yea so I've spotted the good nurses but then to me they are good nurses so someone else could go in and think they're rubbish they didn't have the same ...

Researcher - do you think patients do the same – rate their nurses ?

Yea...because I've had conversations with patients where they want that nurse and they want this nurse When one of my mentors came in they were like oh you're here today ...and they were like oh I mentioned this to the other nurse but it hasn't been dealt with but I know you'll deal with it. I was really yea You just think I want ...

2.0 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?

I think everyone has the kind of like conception of a nurse being that kind caring person who is just lovely and everyone thinks nurses are these well most of them are these kind of like really lovely beings erm..... but then as you actually go into nursing I think you have a realization that although you have to be like that you have to have quite a lot of good time management, quite a lot of other skills as well as those skills that sometimes those skills contradict each other like listening to the patient but good time management and getting all your clinical jobs done there's a really hard balance to be made between

them

I'd never been in a hospital, never done any kind of nursing work or anything like that so I was a bit naive when I came in thinking these nurses were going to be these lovely people (laughs) My first year was my worst year for mentors, my first mentor on my first placement said that I was rubbish ... (Laughs) and erm..... I didn't like the way she practiced so to me I was like... oh my goodness this is what nursing is all about I'm not sure she was telling people what to do rather than I think trying to influence ... not influence their decision that's the wrong wording but advise them that's the right word she was saying no you need to do this you need to do that and to me that wasn't it wasn't up to her what they needed to do it was up to the patient ... (laughs)
Yes so when she then told me I wasn't confident enough I was like no I was standing back because I wasn't happy with what you were doing

Researcher - Did her opinion of you matter to you ?

It did because I wanted as it was my first placement I wanted to make a good impression and it did really upset me but then looking back on it now..... I'm a bit ...I know I'm ok now I've gained that confidence and I've seen better practice so I know I was right to do and act how I did ...I was enjoying it and I kinda then shifted to work with another lady so .. I was, I'm gonna get the most out of this placement

Researcher - do you think you did learn anything during that placement ?

Not to be like her (laughs)I think the more people you meet as well the more your views change because you pick up on different characteristics that you want to have or that you don't want to have or don't want to be like taken something from each person that I was mentored by because they kinda helped me those placements helped me kind of develop into the nurse I am now ... so yea.

Q 2.1 - Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?

Erm ... from Starting my course I again didn't really have much knowledge of what it was so then when I went into hospital I kinda had this these lovely beings that worked really hard that you were then kinda like oh to that now it's quite it's a massive difference ...but its because of like erm trying to explain it not doing a very good job erm how they you learn how it works and like the tricks of the trade I think with nursing they don't have that time management there are ways that you can change and erm .. yea I think it definitely has changed but then I didn't have much knowledge in the first place... I had a very small knowledge base to then going from yea

Researcher - would you have done nursing ?

Erm..... I hope that I would have, I really hope cause I like the person and I like the things I've done I like the things I'm going to do hopefully but if someone told me when I was leaving for my A levels you're gonna be a HCA for most of your nursing trainingwiping peoples bums and cleaning people and things I would have been like oh no ... but that's the part of it I really love nowyea but I hope that I would but don't think I would.

Q3 - What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?

Definitely... I don't think this course should be taught in a classroom ...I think it should be very much hospital based rather than classroom based ermbut then I think that's because I have to do things to learn them ... you could teach it to me in a class room but it wont do me any good I wont learn it 'till I do it until I kind of put an infusion or do the IV's physically do the drug calculations when the drugs are there erm..... I've never I've

never had to deal with patients you've never had to deal with families you've never had to deal with someone dying never had to deal with and you can't teach those things I think you have to experience them and then reflect on them so I think it would be better to do it the opposite way round in that you do it and then come back and say this happened and they can be like ... well next time because you know those feelings so I think its in terms of kind of clinical skills can't be then in terms of like your physical patient care I don't think people can say oh the NMC code says this and it says that I don't think you actually understand it until you go on placement and you think oh I can't talk about that patient because of the confidentiality you don't understand that

Participant Five (P5)

Codes : Profession Learning Influence Interaction Belonging Caring

2.1 - Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?

Erm (long pause) I'm not sure ... (long pause) I think I probably thought it was a lot simpler than what it is now I understand the erm that there's all the policies you have to adhere to and there's now all the time constraints like in A and E you have to be done by 4 hours and all these things and when you are a lay person and you don't know the things behind it you wonder why am I the only discharged yet I've had my tablets so I wanna go whereas now I know that you just have to explain everything to your patient - I know you've got your tablets and your waiting to be discharged but I've gotta go and talk to the doctor or whatever and it's I just understand now slightly like the complexity of it all and the time constraints that you have and it's not just a simple as you've go one patient and you deal with that one patient you've got 6 patients or how ever many patients and you have to prioritise all of their care and identify which ones most important and sort of focus on that and at the same time you've got 4-5 patients waiting for things to be done so I think like being on placement has just shown how complex it is

Researcher - what about nurses as people ?

erm..... I've got a feeling that when your doing nursing for a long time it might change your character so not always but I think there's a, there's certain people that would make amazing nurses and you can tell from just friendships like with the girls that I'm with I can think 'God your going to be amazing' and then there's like hmmm maybe you should be a doctor instead (laughs).... yea you can tell by their personalities so I think when you're in placement you can see which ones are good and which ones aren't so good and you can just pick that up straight away and you can see which ones the patients like more and which ones relate to the nurses and the.... I think its interesting when there's certain nurses that know patients by their bed number and certain that know them by name and its quite confusing like on placement when nurses say oh do this to bed 10 and I'm like who ? what's their name again ? ... and the nurses don't even know and it's a little bit scary but I think that a from experience that's just what it shows....

Yea no I think it just depends there is some lovely nurses that you meet in practice and some that you do just think why are you a nurse ? (laughs)

It's bad to say but it is and I do think to myself sometimes I wouldn't want to be nursed by you and I feel sorry for my patients so then I just go and do a bit of talking and try and make them be comfortable ...

Q3 - What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?

I think the main one is assessing patients that's what.... it's easy to do observations but now like in first year it was just a case of oh I'll do the obs and sort of have a quick look

at them but you don't know the significance whereas now doing our critical care module its making us realize every little aspect that's kinda all of it contributes to something else and you can pick up on things but you..... as many examples as our lecturers give us you cant see the patients so its quite hard to learn how to assess unless you've got a patient in front of you , the other thing would be erm like procedures simple things like taking out a cannula and now were learning about intubation well you , we've got the dummies and they're really good but that's not real life and I know that I've done an intubation with a doctor and it was completely different to doing it on a dummy whereas if you base all your like your stuff on what you're learning in uni when you go out on practice your stuffed really cause its completely different its so different..... I really wanna sort of improve because I've seen really bad practice in like inexperience and it really scares me that when I come out of university I'm gonna think oh my God what, what if somebody dies I will have to tell their family because what I have seen but at uni they are we got a like erm one of our set lectures is about it and it was really informative but I still don't think I'll know how to do it until I sit there and say to a family..... you know I gotta tell you that .. erm I did think of something else as well ...can't think we will have to come back to it

Q3.1 - How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?

I'll obviously go and see the placement and have a little read round and sort of articles and things but you don't really know what you've gotta learn until you're there and then sometimes it might be a bit little too late cause you've just got this patient in front of you and you think oh God why didn't I read that article but it's its easier now because you get your handover sheet and then when I go home I'll sort of look up anything that I don't know and then it means that I know then for the next day when I go in oh you've got this and I've read about that so that's how I'm learning about what to know and sort of when erm mentors say certain things I'll make me read up on it but if they say something that I don't thinknot that it's not right but say its not the same as university then I'll go back and research that and then I'll probably put it into a bit of reflection or something just like evidence for my document and that's usually quite useful and as well that helps my mentor to know what's up to date and what's best

I don't think you can fully prepare yourself, like even if people do read lots before they go on their placement because some of the things you need to do is more like assessments and observations and you can't learn that through an article or book and I think that's where when.... you are on the placement your emerged all the stuff that's when you realize

Researcher - how do you get feedback on how well you are doing ?

It depends on the mentor some of them have been really good like, oh you did really well on the procedure carry on that way whereas others would just sort of let you be and that's that that's it done that if you've done it good or bad you've done it so but it I have had some mentors that have said maybe you could improve on this or you know you'll get this with experience so don't worry about it so much now some of them have given really good feedback and its good to know where to focus on with your next placement but then others aren't so bothered

....yea its hard when you've got a mentor that doesn't seem to want you as a student or doesn't want a student at all. its really hard cause your not trying to impress but you wanna make sure you doing everything properly that it doesn't matter if you do everything right or nothing right either way you wont yea one placement that I was on erm I had a mentor that wasn't really my mentor just my two mentors were off the first week so she stepped in and then said do you want me to sort of help you out and I said of course and half way through the placement she was just demanding 'do this do that do that' we always had to do discharge planning and I was thinking, nobody's actually shown me I'm picking this up as I'm going along and it was hard she never gave good feedback and yet I

had two days off and when I came back she said 'oh I really missed you while you were away' and I was like yea you had to do it all yourself did ya ?(laughs)

(know your name?) ye instead of student, that's not very nice when everyone's like, 'student ! can you do this' and 'I'll get the student to do it', its not very nice you just you know don't feel like anything even if its not you just think to yourself I've come into placement and I've learnt every patients name and everyone of your names why can't you remember one name?, it's really hard but you could, that's another way you can tell if a nurse is good or not because there the ones that take time to say I'll work with you today and you know they introduce themselves and things like that

Q4 - Describe your experience and what it is like when working with a 'good nurse' during clinical placements

It makes your shift go so much smoother and nicer and you enjoy the placement so much more..... just even if you work with one good nurse, one day in the whole placement that's the highlight of your whole placement it just completely changes the way that the placement goes and usually with the good nurses they're the ones that either want get you to do things so not only are you with a lovely nurse you've also enhanced your learning ten fold from the other days when you've been with a bad nurse..... it's so much nicerI think it's the way that they relate to you erm so they sort of see you as an individual and as on the same par rather than some menial student they see you like, like..... like..... an individual like a human being sort of thing they see you as a student that needs to learn so they are gonna like help you learn and its like they take it upon themselves to say did you know this ? did you know that ?, how about we test this ? and it's more challenging rather than a passive mentor that just doesn't really mind what you do they don't teach you for instance with the discharges that I did if she'd have said, right this is what we're gonna do and then you do it this way then every other discharge that I did I would have been confident and I would have know what I was doing and I was thinking brilliant I can do this it makes you want to do the profession and to carry on learning new things especially when they show you how to do things then it means that next time you can think .. oh I can do this I'll do this and then you can say to your next mentor somebody's already shown me can I show you that I can do it because in a few months you'll be on your own and won't have some body stood over your shoulder and I think if you've got those nurses that will teach you how to do it it makes you as a professional probably betterbecause you've learnt how to do it rather than just watched

Q5 - Describe your experience of working in the clinical environment with others and how this influences and supports your learning

we'd have an MDT meeting er ... where I had a few days with the physio. and the occupational therapist and I just thought that they really helped me see the connection between the whole MDT because it meant what they learn and what they were teaching me I could then know for future how to refer or who to refer on to for future patients

Emerging Themes From The Data

Using a three-stage approach to generating themes, I initially reviewed the responses I coded by participant and focus group. I then grouped the coded responses by interview question and participant (*appendix ten - page 196*). By reviewing the responses using the codes discussed in the previous chapter (*table five - page 102*) across all participants, I was able to identify recurring themes, phrases or words. For example when reviewing the first participant question

sections, I noted the recurring use of the term 'care / caring' and this prompted me to revisit the transcripts and re-code for the terms 'care / caring'. Due to word limitations of this thesis, **table seven** on the next page provides a sample of the detail provided in **appendix ten** to illustrate how recurring concepts and phrases were identified.

Table Seven - Sample analysis of student transcripts by participant and interview question.

Participant / Interview Question	Q1 Please tell me what you consider makes a 'good nurse'?	Q1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?	Q2 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?
Student Participant One	a nice <u>caring</u> person be intelligent be quite hard to sort of get over things quite open minded actually <u>does care</u>	need to know your <u>boundaries</u> understand about all the drugs	you meet a really good... say mentor and you think... oh yea you know <u>I'd quite like to be like</u> I think a good nurse as a mentor is someone that is you know <u>they are on the same level as you</u> and you agree with you know with a lot of the things they say and just and they treat patients well as well
Student Participant Two	you have to <u>care</u> about what you do communication is another one	I think they are similar qualities I think they would be similar <u>but know where the barriers</u> sort of is for the professional	I think you see bad practice and I have seen it and I have said <u>I don't want to be like that</u> it makes all the difference and you say oh <u>I'd like to be like that when I qualify</u>
Student Participant Three	someone who is approachable honest responsible professional trustworthy nice but also hardworking	I think in the sense that I mean professional as well as being sort of jolly and happy and friendly and <u>having a relationship with your patient you have to also to do your job properly</u>	It's <u>the actual little things that you actually see on placement</u> that you wouldn't be able to know before
Student Participant Four	<u>care</u> and genuinely got into the profession to look after patients they have time to talk to the patients	they can <u>separate professional from personal</u> but they have this kind of like banter line	Yes so when she then told me I wasn't confident enough I was like <u>no I was standing back because I wasn't happy with what you were doing</u> you pick up on different characteristics <u>that you want to have or that you don't want to have or don't want to be like</u>
Student Participant Five	can make assessments that are holistic really good with their patients	Maybe good communication	I just thought nursing was just a job ... now its so much more complex like <u>my understanding of nursing is much more complex</u>

Summary

This chapter presented my rationale for selecting case study as my research strategy. I then explored the ethical considerations that influenced my method. I identified that I chose to gather data using interviews with the student participants and a focus group of registered nurses. The development of my interview and

focus group questions were outlined and the chapter concluded with a discussion of my reflection and experience on the actual data collection. The next chapter naturally follows on from my data collection and presents the findings and analysis of results, leading into the final chapter that concludes with my recommendations for practice and discussion of the limitations of my work and possible future research building on this study.

Chapter 4 - Findings

Introduction

This penultimate chapter provides the detail relating to my analysis of the findings arising from the student interviews and registered nurses focus group. The findings presented provide the foundation and guide the suggested implications for nurse education that are detailed in the next and final chapter. In keeping with my framework for analysis (page 88), the draft themes I identified were sent to the student participants for review and invitation to comment. One participant responded and was positive in her feedback, stating that,

'I totally agree with all the themes that you have found and think it could really benefit students in the future'.

The other participants did not respond or make suggestions for alterations to their transcripts. A draft copy of this thesis was sent to each student participant and the head of school of each of the universities I worked with to access their student and registered nurse groups. The Open University, chair of the ethics committee was provided with a progress report in compliance with the request made in the ethics memo (**appendix fourteen** – page 214).

Table Eight A on the next page details the initial four codes I used; professional, learning, influence and interaction. I was able to establish four key themes, one for each key word and eight related sub themes based on participant comments. Once the initial themes were developed I then aligned the existing literature to each theme where previous findings reflected and supported my findings/themes. For my second stage of analysis I examined the results of my coding by category related to the components of a social theory of learning (Wenger, 1998); learning as becoming, doing, experience and belonging as detailed in **appendix eleven** - page 204.

The analysis of the student transcripts by components of a social theory of

learning (Wenger, 1998) supported the development of a further four key themes and eight related sub themes. **Table eight B** on the next page provides the detail of the themes developed.

For the final, third stage of analysis I reviewed the student transcripts against the four NMC competency domains (**appendix twelve** – page 211). While the analysis using the NMC domains was not intended to produce or contribute to theme development, I used the findings to externally validate the experiences described by the student participants. As a framework developed by the professional regulator to define the level of competence of newly qualified nurses, the NMC domains provided a useful means of aligning the participant responses against the new regulator expectations for practice and judging the potential authenticity and legitimacy of the responses provided by the student participants.

The construction of **table eight – A, B and C** on the next page was my first step in starting to understand the data following initial analysis and was my approach to undertaking pattern matching, an important element to maintaining internal validity (Yin, 2009).

Table Eight A – Stage one analysis – research question

Framework for Analysis	Research Question			
Codes	Profession	Learning	Influence	Interaction
Themes Identified	Theme 1 <i>Caring as the basis of nursing</i> sub themes - Professionalism and competence represented as good nursing - Image of nursing influenced by good nurses	Theme 2 <i>The 'luck' of learning</i> sub themes - Learning the routine - Students determine their own learning	Theme 3 <i>Good nurses actively teach and support learning</i> sub themes - Others influence student attitudes to learning - Good nurses demonstrate the 'little things' that make a difference	Theme 4 <i>A sense of belonging supports learning</i> sub themes - Students want to be valued 'learn my name' - Students want to be part of the clinical team
	<i>Qualities of mentors, Gray and Smith (2000)</i> <i>Influence of 'good' nurses, Donaldson and Carter (2005)</i> <i>Caring, Solvoll and Heggen (2010)</i>	<i>Norms of behavior and ward routines, Earnshaw (1995)</i> <i>Professional knowledge, Spouse (2001b)</i> <i>Routines, Pearcey and Draper (2008)</i>	<i>Role models, Baillie (1993)</i> <i>Influence of mentors, Pearcey and Elliott (2004)</i> <i>Exemplary nurses, Perry (2009)</i>	<i>Need to be part of clinical team, Nolan (1998)</i> <i>Belonging, Levett-Jones and Lathlean (2008)</i> <i>Becoming part of the clinical team, Newton et al. (2009)</i>

Table Eight B – Stage two analysis – social learning theory

Framework for Analysis	Social Learning Theory Wenger (1998)			
Codes	Becoming	Doing	Experience	Belonging
Themes Identified	Theme 5 <i>Good nurses inform professional identity</i> sub themes - Learning from the negative - Recognising good and bad practice	Theme 6 <i>In the clinical environment you learn what can't be taught elsewhere</i> sub themes - Learning is 'real' in the clinical environment - Interaction and communication with patients and staff	Theme 7 <i>The clinical environment provides unique learning opportunities</i> sub themes - 'Tricks of the trade' and the 'little things that matter' - Observing others supports learning	Theme 8 <i>A sense of belonging supports learning</i> sub themes - Responsibility and Trust - Valuing and respect 'names are important'

Table Eight C – Stage three analysis – NMC (2010b) competency domains

Framework for Analysis	NMC Competency Domains (2010)			
Codes	Professional Values	Nursing Practice and Decision Making	Communication and Interpersonal Skills	Leadership, Management and Team Working
Relevant Key Words Identified from student transcripts	Caring - Helping, Confidentiality-Honesty - Trustworthy, Boundaries, Confidence, Knowledge.	Treat patients well, Autonomous, Responsibility, Making decisions, Assessment.	Relationships, Communication, Interaction, Talking with patients.	Politics, Leadership and delegation, Time management.

The detail provided in **table eight A and B** produced eight key themes and sixteen sub themes. The eight key themes were;

- 1 - Caring as the basis of nursing,
- 2 - The 'luck' of learning,
- 3 - Good nurses actively teach and support learning,
- 4 - A sense of belonging supports learning,
- 5 - Good nurses inform professional identity,
- 6 - In the clinical environment you learn what cannot be taught elsewhere,
- 7 - The clinical environment provides unique learning opportunities and
- 8 - A sense of belonging supports learning.

An overview of all the themes is provided in **Appendix thirteen** (page 213). On reviewing the eight key and 16 sub-themes identified, I wanted to relate the themes to my research question. I grouped each key theme and sub theme together using the criteria of either; ***influence of registered nurses*** or ***student learning experience***.

This final step of grouping the themes allowed me to generate four final themes; three relating to the influence of registered nurses and one reflecting the student

learning experience. The three final themes relating to the influence of registered nurses on learning were; *responsiveness to student learning needs, creating a sense of belonging* and *influencing professional identity development*.

The fourth theme emerged relating to the student learning experience was, *in the clinical environment, students learn what cannot be facilitated elsewhere*.

Diagram four on the next page provides a nested overview of the four final themes; *responsiveness to student learning needs, creating a sense of belonging, influencing professional identity development* and *in the clinical environment, students learn what cannot be facilitated elsewhere*.

It was interesting to note that the three key themes relating to the interaction of others on learning in the clinical environment, chimed with the NMC mentorship framework mentioned in chapter one (page 18). While the fifth NMC domain, *creating an environment for learning* of the NMC (2008) *Standards to support learning and assessment in practice*, is broad in context, it does as an example, reflect the focus of my four key themes. **Table nine** on the next page provides an overview of how I considered my developed themes related to the NMC (2008) *Standards to support learning and assessment in practice*, which I believe demonstrates the congruence between my findings and the established professional standards.

Diagram Four - Four key themes identified from the data analysis

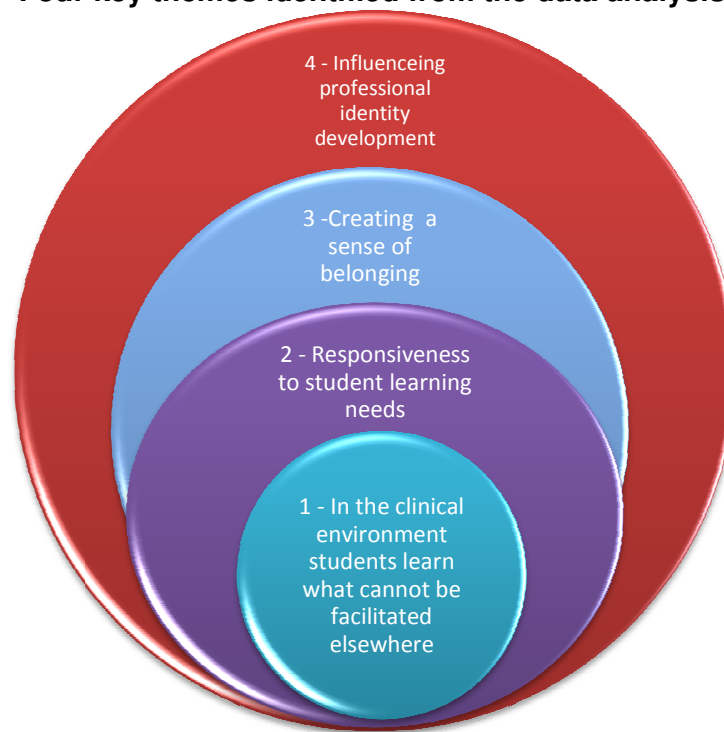


Table Nine – Four key research themes in relation to the NMC domain standards to support learning and assessment (NMC, 2008)

NMC frame work domains / Key Research Themes	1 Establishing effective working relationships	2 Facilitation of learning	4 Evaluation of learning	5 Creating an environment for learning
<i>responsiveness to student learning needs</i>				
<i>creating a sense of belonging</i>				
<i>influencing professional identity development.</i>				
<i>in the clinical environment, students learn what cannot be facilitated elsewhere.</i>				

The next section of this chapter deals with the four key themes generated and their associated sub themes. Taking each theme in turn, I detail the development associated with that theme and discuss the findings. Relevant examples from the student and focus group transcripts are provided to demonstrate the evidence informing my analysis.

Diagrams are provided for each theme to provide a visual representation and based on the advice provided by Miles and Huberman (1994) who argued that good data diagrams and displays are, '... a major avenue to valid qualitative analysis' (p.11).

Theme 1 - In the Clinical Environment Students' Learn What Cannot be Facilitated Elsewhere

The first key theme discussed is the one relating to the clinical environment. I believe it is important to start with this theme since the clinical environment provides the context of learning and was a focused element of my research question. This theme is designed to reflect the concept that there is a form of practice learning that needs to be experienced and can best be gained by actually doing and providing nursing care.

From a review of participant responses there were a number of examples where student participants described in their recollections of learning, how their knowledge and learning was influenced and developed in the clinical environment and from others. The descriptions provided by the students suggested that learning in the clinical environment provided different learning opportunities from those in university and that the learning process and experience was different. The experiences described supported the argument discussed earlier in the thesis (page 71) and reflects learning *in practice* as described by Loughran et al. (2003). An example of learning in practice is provided by participant three who described her growing realisation of the skills she needed to develop as a result of her clinical placement,

'I think there's a lot of leadership skills that a nurse, a good nurse needs to have that I've only sort of realised and learnt from, through being on placement because you can only, before being in that environment, you can have a view but you can't know what ... what nurses do on a day to day basis' **P3**

Student four also describes a realisation she had as a result of experiencing nursing in the clinical environment,

'... but then as you actually go into nursing I think you have a realisation that although you have to be like that you have to have quite a lot of good time management, quite a lot of other skills as well as those skills that sometimes those skills contradict each other like listening to the patient but good time management and getting all your clinical jobs done there's a really hard balance to be made between them' **P4**

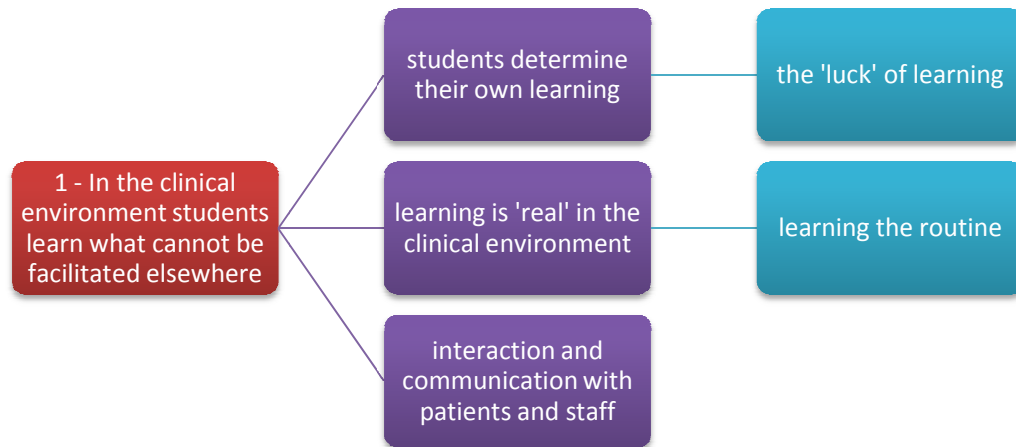
The demands and complexity of nursing was also described by participant five, who spoke about time constraints,

'so I think like, being on placement has just shown how complex it is' **P5**

'I think I probably thought it was a lot simpler than what it is ... now I understand the, that there's all the policies you have to adhere to and there's now all the time constraints' **P5**

The theme of *in the clinical environment, students learn what cannot be facilitated elsewhere* has five associated areas and these and their relationship to each other are detailed in **diagram five** on the next page. **Diagram five** starts on the left side with the key theme and then branches into three related sub themes, two of which have their own sub theme. This diagrammatic approach is also taken for the remaining three key themes. The diagrams represent relationships between the key and sub themes and are not intended to be hierarchical. For example in the sub theme *students determine their own learning* I consider that students' identification of *the 'luck' of learning* is related to and a factor in their determination of their own learning. Equally, with *learning is 'real' in the clinical environment* the importance and influence of *learning the routine* featured as an important element of the 'real' learning.

Diagram Five – In the clinical environment students' learn what cannot be facilitated elsewhere



Students' determine their own learning

Recognising the variability of learning opportunities in the clinical environment, this sub theme reflects the way student participants described how they managed their learning in the clinical environment. There was a strong indication from the student participants that their learning outcomes in the clinical environment were determined by what they perceived as important, an almost 'gut feeling' approach. While a number of participants discussed assessment documentation provided by their university, this was generally perceived as unhelpful,

'I don't know how you do know what you need to know - I think you just (long pause) the booklets we get, the CAP documents don't really say much about what we need to learn - I found myself repeating a lot' **P1**

'I think well, my... how do I know what I need to learn is in my CAP document which is a very odd document' **P4**

Four of the five student interviewees spoke about how they determined what they needed to learn in the clinical environment,

'I don't know how you do know' **P1**

'I think you just get a feel of what you're capable of and if you have a good mentor that sort of pushes you' **P1**

'I think you have your own idea of what you would like to do' **P2**

'thinking about the placement we have just done - I think we knew, well I knew what I needed to achieve' **P3**

'it's more up to us to decide with our mentor, do we need to do anything' **P5**

Participant one gave a strong description of how she perceived her responsibility to control her learning, regardless of mentor support,

'There's only so much your mentor can do, take a proactive approach, so yea I think a lot of people say, oh yea my mentor wasn't that great which is true, you can get some not really good, but you've got to be... stand up and say, I want to do this' **P1**

In comparison, the registered nurse focus group was more reliant on structured guidance in supporting them to determine learning outcomes and spoke about information provided by the university, for example,

'they have objectives they give you' **Focus Group**

When asked how nurses and mentors know what to teach, one focus group participant suggested that they,

'see what your ward has to offer and what you know as a qualified nurse, the basics' **Focus Group**

While the student participants demonstrated an ownership of their learning needs, overall there was an impression that individual students needed to identify and be sufficiently motivated to gain learning opportunities. This does pose the question of what the learning experiences are of those students that do not have this motivation. This is a potential sample bias in that my findings are not representative of less motivated or able learners. As final year students, the descriptions made by participants may demonstrate that over time they developed these approaches to learning as a result of previous experiences of unstructured

clinical learning. This potentially *ad hoc* and variable learning experience is reflected in the next related sub theme that I have entitled the ‘luck’ of learning.

The ‘luck’ of learning

The description by students of managing their learning may in part be due to the serendipity or recall of what appears to be the unstructured nature of their learning. The responses from a number of the student participants indicated the low level of expectation they had of good learning experiences in the clinical environment. Two students made reference to being ‘lucky’ in having what they considered good mentors and / or clinical experiences,

‘actually I think I have been really lucky - and had good mentors’ P1

and

‘but that’s luck probably, ‘cause I know some [mentors] aren’t so helpful’ P3

The students had a clear view that their learning was very much dependent on the mentor or registered nurse they were aligned to, indicating that the variability in learning discussed in chapter two (*page 67*) experience remains and continues;

‘you have to make the best out of a bad situation ...’ P2

‘yea, it’s hard when you’ve got a mentor that doesn’t seem to want you as a student or doesn’t want a student at all’ P5

‘it’s [experience of nursing] very much dependent on who you’re working with and what sort of type of nursing you’re doing’ P3

Participant three introduced the element of ‘chance’ in describing the variability of learning experiences, which she perceived as being better if working with a ‘good’ nurse,

‘also if you’re working with a good nurse - you probably have a better chance to learn a lot more and learn the correct way to do things’ P3

Student four described from her perspective how unplanned learning opportunities

were and both student and nurse appear to rely on each other to identify learning outcomes,

'I think you gauge from your placement rather than you being told, I ask my mentor what am I gonna get from this placement ? because they always ask, what do you want ? and it's like well, I don't really know, I've been here two days (laughs) I don't know what I can get from this placement so it's quite nice for someone to outline to you the opportunities available to you' **P4**

A focus group member also demonstrated an awareness of the limiting effect poor mentor support could have on a students' ability to learn in the clinical environment,

'from observing what mentors are like, if you have a good mentor who's caring and takes time to teach or whatever or if you've got a mentor that's under pressure and is stressed and keeps brushing you off, you know it does have an effect on the skills you're going to learn' **Focus Group**

Student participant five also supported this view on the variability of the learning experiences available,

'it depends on the mentor, some of them have been really good' **P5**

One of the focus group registered nurses offered an approach to managing the variability of clinical learning experience while acknowledging the difficulty,

'But you can still be pressured and handle the students caringly and say look - our area is quite pressured but explain and just, just observe don't take it personally it can be difficult' **Focus Group**

Learning is 'real' in the clinical environment

This theme reflects the descriptions by the student participants that the learning gained in the clinical environment as a result of providing care or 'doing' nursing, was seen as important since it was 'real' and provided more effective learning

experiences than through simulation or class room based teaching.

An example of how student four identified 'classroom' based teaching as providing knowledge *for* practice and student four's realisation of the equal importance of gaining knowledge *in* practice is demonstrated in the following quote,

'... you could teach it to me in a class room but it won't do me any good, I won't learn it 'till I do it, until I kind of put an infusion or do the IV's, physically do the drug calculations when the drugs are there' **P4**

and this perspective is supported by participant five who said,

'... we've got the dummies and they're really good but that's not real life and I know that I've done an intubation with a doctor and it was completely different to doing it on a dummy, whereas if you base all your ... like your stuff on what you're learning in uni. when you go out on practice your stuffed really cause it's completely different it's so different...' **P5**

'... I think it should be very much hospital based rather than classroom based, but then I think that's because I have to do things to learn them' **P4**

The student participants were able to give examples of the types of knowledge and skills they believed could only be gained in the clinical environment, for example;

'just different situations that you might not have a clue what to do in, but only learn from doing' **P3**

'You can't teach what someone is going to be like if they have an illness until you see it I think' **P2**

'... as many examples as our lecturers give us, you can't see the patients so its quite hard to learn how to assess unless you've got a patient in front of you' **P5**

'there's just a lot of experiences that you may not expect, that you can't be taught how to deal with in a classroom' **P3**

'but definitely things like that like the role ...the role of other people around you like health care assistants ...and the different roles in nursing like sisters and staff nurses, things like that there's a lot of things that we're taught like how to give injections, how to do CPR, all that, all those kind of clinical skills we're taught in the classroom before we go but ...it's very different giving an injection to a real person who might be terrified of needles to doing it on a little dummy of an arm (laughs)' P3

'people can say oh the NMC code says this and it says that I don't think you actually understand it until you go on placement and you think oh I can't talk about that patient because of the confidentiality you don't understand that' P5

'much better learning in the clinical environment and also being able to deal with sort of spur of the moment unforeseen circumstances ... like dealing with patients and also dealing with their families dealing with visitors relatives people who might be difficult' P3

The students clearly value the knowledge, skills and experience gained in the clinical environment and the uniqueness of the 'real' learning. An important element of clinical learning discussed by the students was the importance of learning the routine.

Learning the routine

When describing the unique learning that can occur in the clinical environment, student participants identified the value they attached to understanding the clinical or ward culture and routines. Examples include;

'Definitely just the ward environment for me - I know it sounds silly - because the first time I was ever on a ward working was my first placement and I didn't even know what handover was or and just like these little things you don't get told about in lectures' P1

'like the politics and things I think you don't realize and I didn't know what uniforms meant and who was sort of the top dog of things and I think you just learn from like experience and just think oh ok' **P1**

'Patient interaction, I think as well patient interaction with ill people, I think I found that quite hard when I came in - I didn't know what to say to people' **P2**

'just knowing what a nurse does because I'm sure I didn't know before, before my first placement like the running of a ward - the day sort of - yea routine' **P3**

'so just the basics you know routine of a ward and what happens on it and stuff like that' **P1**

This finding is supported by the research undertaken by Earnshaw (1995) who reported that nursing students found that mentors were relied on to convey and teach ward culture and routines. The final aspect of learning in the clinical environment described by the student participants related to the opportunity to learn and experience interaction and communication with patients and staff.

Interaction and communication with patients and staff

In describing the overall uniqueness of the clinical environment, one specific aspect of nursing was discussed by students; interpersonal relations and communication with patients and their relatives. Student two described her initial experience and lack of preparation of how to communicate and interact in the clinical environment,

'... think I found that quite hard when I came in I didn't know what to say to people I didn't know how to go about ... about my manner, I don't know... when someone is acutely ill ... like I wasn't sure 'cause ... you can't be taught how to interact or talk' **P2**

This experience was also described by participant four,

'... and it's that 'cause I've never, I've never had to deal with patients, you've never

had to deal with families you've never had to deal with someone dying never had to deal with and you can't teach those things I think you have to experience them and then reflect on them' **P4**

'... relationships and things, you know, you don't know with your mentor with staff and patients that obviously 'cause that can't be taught can it? different patients and people that you meet' **P1**

'like dealing with patients and also dealing with their families, dealing with visitors relatives people who might be difficult' **P3**

The experiences described were clearly challenging for the students, however they did not appear to expect to have the knowledge and skills prior to going into the clinical environment - *'you can't be taught how to interact or talk'*

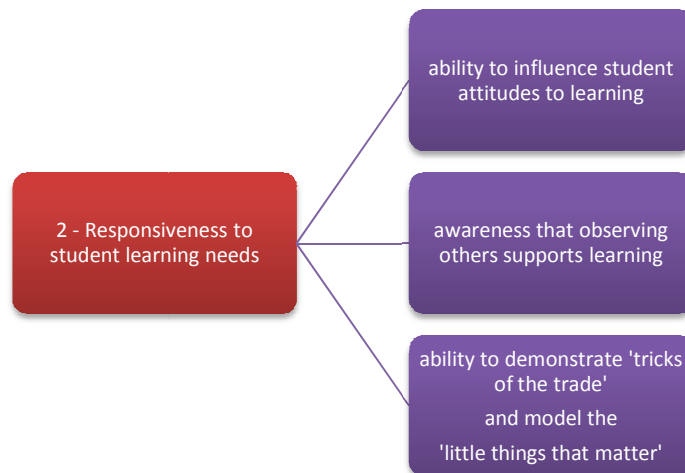
and expected to gain the skills once on their placement. There was no description of how these communication and interaction skills were gained, except for the need to *'experience them and then reflect on them'*

This finding reflected one of the categories identified by Spouse (2001b) relating to patients and their relatives (category of knowledge) in her research, which was discussed in chapter two (page 57).

Theme 2 – Responsiveness to Student Learning Needs

This theme was developed to capture the evidence that nurses, who were perceived as good, were also described as having an interest in student learning and progression and demonstrated this by actively supporting and facilitating learning opportunities. The comment made by student participant five, when describing good nurses as the ones who *'want to get you to do things'* implies that these registered nurses are actively encouraging and providing opportunities to gain experience and as a result support learning. This key theme has three associated sub themes, which are detailed in **diagram six** below.

Diagram Six – Interaction with others: responsiveness to student learning needs



Participant five perceived the influence of a supportive nurse as so significant and influential to her learning that she described good nurses as,

'the ones that either want to get you to do things, so not only are you with a lovely nurse, you've also enhanced your learning ten fold from the other days when you've been with a bad nurse' **P5**

Participant four and one also spoke about 'good' nurses wanting to support their learning,

'it's kind of more like, more of an equal to them and they were really trying to extend my learning and really, they wanted to help me' **P4**

'if you do have a good mentor that sort of pushes you, but you know is gonna sort of assist you on the way' **P1**

The experience of having a positive role model who also 'made time' for teaching was highlighted by a focus group nurse participant, who said that,

'If you think back to your training - think of the people you respected and thought, I want to be like that, good role models, a good mentor had time for you as well, explained things instead of just go do this, go do that' **Focus Group**

Student participants also described activities and approaches used by those who actively supported them to develop their learning such as;

'Personally I had a really good mentor in my last placement and she was very keen to know what I wanted to learn and helped me - like tell me the sorts of things I should be learning on that particular placement and also give me the feedback I needed on whether I'd done it correctly or whether - like, if there were more things I needed to do' **P3**

'if people, when you are in a team, if you're - If someone has got something interesting, they'll say come and look at this, come and see this, do you want to do this ? do you want to do that ? as opposed to you having to always go and say have you got anything to do ? what shall I do ? - yea and just including you in what they are doing, I think more than just having to please yourself' **P2**

' they see you as a student that needs to learn, so they are gonna like help you to learn and it's like they take it upon themselves to say - did you know this ? - did you know that ? - how about we test this ? and it's more challenging rather than a passive mentor that just doesn't really mind what you do they don't teach you' **P5**

'I like the people that sort of do little tests, yea you don't like them for it, testing on the drug but it is a good thing and you are going to thank them for it in the end - yea they want to help you' **P2**

Ability to influence student attitudes to learning

When describing working with a 'good' nurse, the student participants were able to describe very positive feelings and talked about and could identify influences on their learning;

'I was relaxed as well even when she [nurse] was watching me, I didn't feel like she was judging me or anything ...' **P1**

The influence of others was described positively by participant two as both motivating and also cementing the desire to become a nurse - *'that's what I want to do'*,

'one word comes to mind – motivating, and it makes you, if you have a good day, you think – yes, that's what I want to do' **P2**

'if someone seems un-motivating and doesn't want to help you... You're like I don't really care, whatever, but if they are and encourage you to do things then you think yea, I want to learn and you might, whether it's go away and look at something in a text book or whether its going up to someone and saying, can I help you with this? can I help you with that? but yea, you just, it is motivating and encouraging to do something' **P2**

Student participant three, expressed a similar sentiment to student two in terms of emotion, self esteem and confidence,

'.... It just makes you feel a lot more positive and happier about what you're doing and like, you're value, you can be sort of as good as everyone else' **P3**

'I think it makes a massive difference to your confidence' **P3**

Interestingly, the experience of learning from a good nurse was described as transferring that quality onto the learner and the perception of actually being a nurse was clearly important,

'I felt like a good nurse, I felt I was being treated as a nurse rather than a student or HCA' **P4**

Participant four made an important distinction as to how her learning needs were positively perceived, as seeking professional advice rather than her 'not knowing' in this example,

'they said that if I didn't understand to go to them, which was nice to have that reassurance, that they wouldn't see it as if I didn't know what I was doing, I would be seen as me just going to them for advice' **P4**

The approach of treating and seeing learners as fellow colleagues and respecting their contribution to the team was described by participant five as,

'it's so much nicer, I think it's the way they relate to you, so they sort of see you as an individual and as on the same par, rather than some menial student they see you like, like an individual, like a human being, sort of thing' **P5**

'you just want to learn if you've got someone who's good at their job, that's how you want to be if that makes sense – so it makes you want to learn, you want to'

P4

Awareness that observing others supports learning

Observation and seeing registered nurses provide nursing was one approach student participants said were able to learn from others in the clinical environment, for example;

'I like just watching what other people do and you pick up everything - I think with quite a lot of things - I guess it's why bad habits get picked up as well just - watching people' **P2**

'I think it's 'cause you meet so many different nurses that do things their way and you know everyone does it different it's just ... you know it's not right or wrong' **P1**

'yea .. it's always nice to work with other people just to see how they do it, always reassuring when it's the same across the board' **P1**

'I think you see bad practice and I have seen it and I have said, I don't want to be like that' **P2**

Ability to demonstrate 'tricks of the trade' and model the 'little things that matter'

The final sub theme in category of *actively teach and support learning*, describes the subtle and potentially unique learning that may be gained from good registered nurses. The 'little things' were seen as the 'correct way to do things' and aspects of nursing care that the participants considered as good nursing. Again, the findings from my study resonate with Loughran et al. (2003) and this sub theme provides examples of students gaining knowledge of practice. The descriptions of experience in this sub theme point to students gaining access to craft knowledge or the subtleties of nursing practice that are not articulated or formally taught. Participants three and four summarised this sub theme with comments that,

'it's the actual little things that you actually see on placement that you wouldn't be able to know before' **P3**

'you learn how it works and like the tricks of the trade' **P4**

As well as influencing feelings and emotions, the student participants were able to describe how good nurses influenced their learning and also used examples of what they considered to be 'good' such as;

'... also if you're working with a good nurse ... you probably have a better chance to learn a lot more and learn the correct way to do things' **P3**

'but they have this kind of like banter line where they use it to bring out people's emotions and to get to what they're feeling' **P4**

'When one of my mentors came in they were like, oh you're here today ...and they were like, oh I mentioned this to the other nurse but it hasn't been dealt with, but I know you'll deal with it' **P4**

'nurses that are really good with their patients, like their patients enjoy talking to the nurse and the nurse has time to, to just have a quick chat, and not just deal with a take a cannula out, and then go like sort of how ya doing, was that ok ? those kind of things giving them a bit of time' **P5**

'doing our critical care module it's making us realise every little aspect that's kinda all of it contributes to something else and you can pick up on things' **P5**

'People - I think who go out of their way to spend extra time with someone' **P2**

As identified earlier, student three discusses 'the little things' or possibly craft knowledge that she believes could not be gained without experience in the clinical arena,

'.... it's the actual little things that you actually see on placement that you wouldn't be able to know before' **P3**

and participant one describes the 'little things you don't get told',

'the first time I was ever on a ward working was my first placement and I didn't even know what handover was or and just like these little things you don't get told about in lectures' **P1**

My findings in this sub theme are supported by the previous work that indicated that exemplary nurses attend to the 'little' things and act as effective role models Perry (2009).

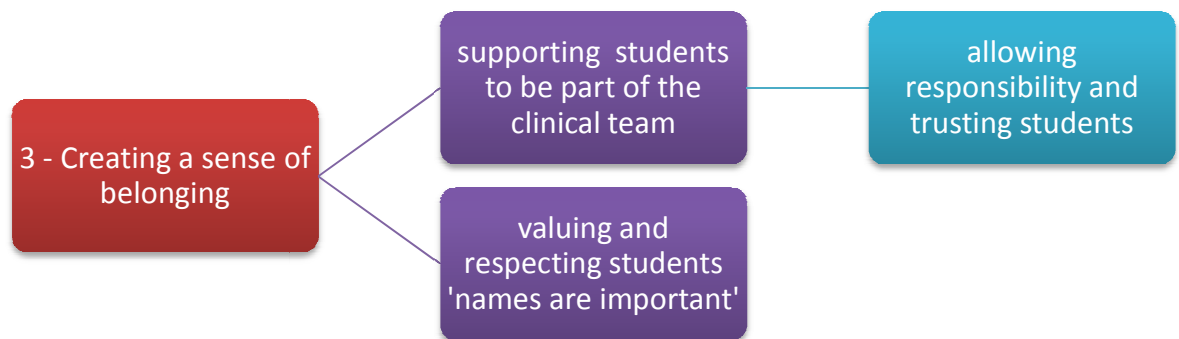
Theme 3 – Creating a sense of belonging

The importance of belonging as a positive influence on learning was identified in the literature review (Levett-Jones et al., 2009) and is one of the four components of a social learning theory framework (Wenger, 1998) applied in this thesis. There were a number of examples where students' gave examples from their experience of how being valued and engaged with clinical teams had a positive influence on their learning. This theme was developed from the coding 'interaction with others'

and 'learning as belonging'. These codes drew out the interpersonal relationships with others in the clinical environment and had a strong emphasis on belonging and values such as trust, respect and being valued.

This theme has two sub themes with one further sub theme associated with supporting *students to be part of the clinical team*, and they are outlined in **diagram seven** below.

Diagram Seven – Interaction with others : creating a sense of belonging



The student participants spoke a lot about their need to be included as part of the clinical team and how when they were not integrated into the team that they felt their learning was diminished, for example;

'yea, I think so because you miss out on quite a lot of things you could see if people were including you' **P2**

'I think people find the time hard to manage and a student then becomes a hassle - which actually if they utilised us, we're an extra member of the team to do jobs, but I think it depends how we're seen as a hassle or helpful (laughs)' **P2**

Supporting students to be part of the clinical team

There was some recognition from the registered nurses of the need to involve students in the team, with one focus group member stating,

'If you think back to your training - think of the people you respected and thought, I want to be like that, good role models, a good mentor had time for you as well, explained things instead of just go do this go do that' **Focus Group**

Student participant two described her approach to being accepted,

'you have to try and put yourself out there' **P2**

'If you're with a nice team that as a student make you feel welcome and you actually want to learn there' **P2**

'yea I think so, if they are friendly to you and yea and just like trust you to do things and send you off and like know you will do it and not keep asking you but yea and also just at the end of the shift saying like thanks or whatever' **P1**

'if you're included, if you're encouraged and like you might not want to do something, but they say – go on do it, you feel like – oh, I have achieved something today and it just makes you want to be there, yes I think it's just encouraging and motivating' **P2**

My finding of the participants' description of the need to be part of the clinical team reflects Nolan's (1998) earlier discussed findings; where students described their experiences of adjusting to the clinical environment from university and the feelings of 'not belonging' in the clinical environment. Equally the findings from Newton et al. (2009) also support this theme, again stressing the importance to students of becoming part of the clinical team.

Allowing responsibility and trusting students

The importance of responsibility and trust were cited as important elements in allowing students to have a sense of belonging and when they were given responsibility and felt trusted by the clinical staff, students said their learning was increased.

'just like trust you to do things and send you off and like, know you will do it and not keep asking you' **P1**

'I think a good nurse as a mentor is someone that is ... you know they are on the same level as you and you agree with you know with a lot of the things they say'

P1

'... first she was describing and then she showed me and sort of said do you, are you comfortable to take part in the next one? yea and relaxed as well, even when she was watching me, I didn't feel like she was judging me or anything you know sort of you know' **P1**

'.... but in a team finds it hard like just to include you and to show you bits, you find it hard to integrate and always feel like an outsider' **P2**

Valuing and respecting students - 'names are important'

There were examples from the student transcripts where participants identified how they wanted to be valued and respected; one way this was expressed was through the use of their name rather than as 'student', for example,

'student do this ... student do that ...and I think a name does make all the difference' **P2**

Equally, participant five identified a good nurse as someone, who did actually learn their name,

'that's not very nice when everybody's like – student! Can you do this and - I'll get the student to do it, it's not very nice you just, you know, don't feel like anything even if it's not, you just think to yourself – I've come into placement and I've learnt every patient's name and every one of your names, why can't you remember one name ?' **P5**

that's another way you can tell if a nurse is good or not, because they are the ones that take the time to say – I'll work with you today and you know they introduce themselves and things like that' P5

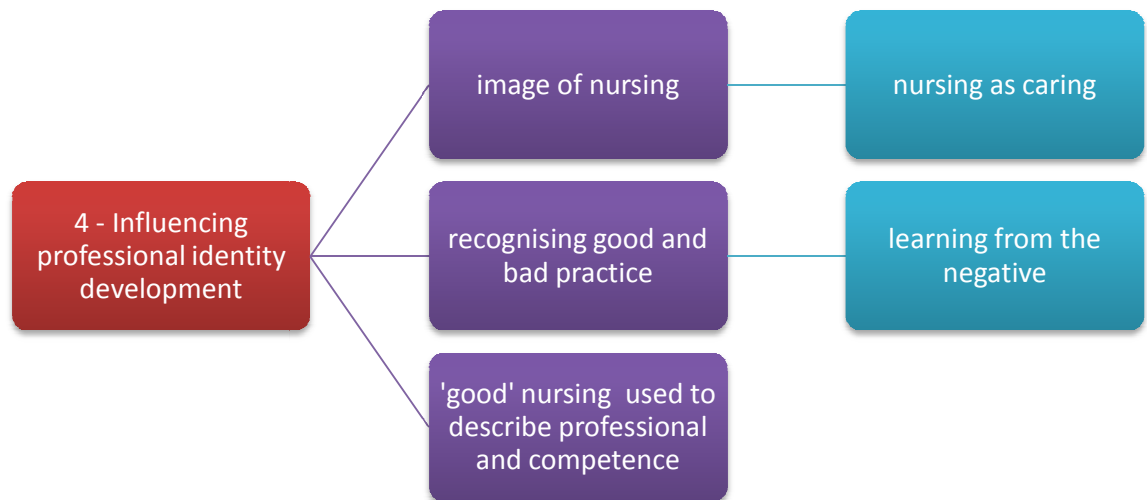
Theme 4 - Influencing professional identity development

In chapter one I identified my position on learning as changing,

'.... who we are by changing our ability to participate, to belong, to negotiate meaning' (Wenger, 1998, p. 226)

and this perspective is reflected in my research question, which focuses on *Becoming a Professional* to identify my concept that the experience and learning that nursing students' undergo is effective when it results in their ability to participate, belong to the profession and negotiate meaning to create their own nursing identity. Five sub themes were identified in relation to the key theme of influencing professional identity and they are detailed in **diagram eight**.

Diagram Eight – Interaction with others : influencing professional identity development



There were a number of examples from participants of how good nurses helped to shape the students' perceptions of the kind of nurse they wanted to be, for example;

'I remember actually coming back home and being thinking that that's the kind of nurse I would like to be' **P1**

'and you say oh I'd like to be like that when I qualify' **P2**

'I don't think when I came in, I didn't really, I didn't have any experience of nursing or anything ... so I went in and I have just built on this, finding out what they do I think I had the stereotypical view of what a nurse does, but now you've ... I've got a rounded view that, yea .. that you do lots of good' **P2**

The following comments demonstrate I believe, a growing awareness of professional identity creation by the student participants. Participant one was able to distinguish between her own identity and that of a nursing student when she stated that,

'I think you put on a professional front' **P1**

Image of nursing influenced by others

There was recognition from some participants' that their image of nursing and the kind of nurse they would be was influenced greatly by others, for example,

'she [mentor] was just really nice to the patients as well and, and I remember actually coming back home and thinking, that's the kind of nurse I would like to be'

P1

'I hope that I've taken something from each person that I was mentored by because they kinda helped me, those placements helped me kind of, develop into the nurse I am now' **P4**

The examples provided by the student participants suggest that good nurses in particular provide strong role models and create an image that the students aspire to. It may well be that students are observing behaviours and forms of communication that they admire. This experience may explain their difficulty in describing competence since this is not easily observable.

Caring as the basis of nursing practice

Both students and registered nurses in their interviews frequently used the term caring. Of the five student participants, three directly mentioned caring and three of the registered nurses also made reference to the importance of caring in nursing. The concept of caring appeared to be used to describe firstly, the motivation to become a nurse and secondly an overall attitude and approach to nursing practice. Some of the comments made by participants that illustrate this theme include;

'I think you have to be a nice caring person in general' **P1**

'.... someone who actually does care about - you know - care about people, and their job how what they can do affects other people' **P1**

'a good nurse, they care and that they want to help people' **P2**

'but I think you can learn how to deal with situations which might, you know make you care for someone - like with family members, I think you can learn the right things to say – but I do think you got to want to care - you know that's what it is - inside you want to' **P1**

'Someone who cares and genuinely got into the profession to look after patients'
P4

Experienced nurses also used the term caring and there was a strong group support for the experienced nurse who stated that,

'Pressures as well, because a lot of us came into, to look after and care for people but paperwork and everything else, so you're not as a qualified nurse, you're not actually doing the patient care which is what you came in to do, you're having to deal with phone calls and ward rounds and the chance to do hands on care is very limited as a qualified nurse' (**Focus Group**)

The references to caring and patient care by students and focus group participants demonstrate the enduring influence of these concepts in reflecting the much

earlier work by Girot (1993b). In Girot's (1993b) work, caring and a patient focused attitude were described by ward sisters as important components and indicators of nursing student competence.

There is an obvious tension between the concerns raised in chapter one relating to issues about the lack of good nursing care and a very strong emphasis from the student and experienced nurse participants in my study on the importance of caring. It may well be that those I interviewed were expressing the ideal of nursing as they perceived it, rather than the reality as they had experienced it. The experienced nurse comment where '*paperwork and everything else*' was used to explain a reduction in '*hands on care*' was identified as an issue by the student participants also, for example participant four who stated,

'those skills [good nursing] contradict each other like, listening to the patient, but good time management and getting all your clinical jobs done, there's a really hard balance to be made between them' **P4**

Student participant three was aware of the professional responsibility for ensuring standards of care and described her realisation that nursing was 'more than a job' in her comment,

'but with nursing you're actually influencing someone else's life ... like you're giving care to someone and you don't want to compromise their care...' **P3**

Participant two while discussing the importance of good nurses interacting with patients spoke about her experience of some registered nurses who were not focused on direct patient care, as she perceived it,

'then you just get the people who do the paperwork, give out the drugs and that's that and the patient contact becomes a lot less' **P2**

When discussing her thoughts on future promotion and the role of senior nurses, participant two described her impressions of one ward manager as,

'I've seen that you don't get, you don't get the - patient contact any more it's all paperwork so yes you might be good in your job to get you up the bands, but I don't think that makes you a good nurse at all and a sister I've just worked with didn't have the communication skills and I think went about her contact in completely the wrong way because she sits in an office all day and she directs everybody' **P2**

While caring is perceived and reported as essential for good nursing, the student participants also frequently cited having knowledge as an important quality. The experienced nurses also identified knowledge as important, however there was a slightly negative inference from some of the focus group participants to knowledge without clinical skills;

'You've got to also have the knowledge to do it but having the knowledge doesn't necessarily make you the better nurse' **Focus Group Participant**

'You've got to be academic but if you're academic you might not be practical - you've got to have common sense' **Focus Group Participant**

While caring was identified as an essential component of nursing, when asked to talk about their views on nurses it is clear that not all nurses are seen as caring by the student participants. The student interviewees made comments such as;

'but I think I've met a lot more - not really nice people and I was surprised at how, as it's meant to be a caring profession - that I'm surprised that there is so many just not very nice people really' **P1**

'I think everyone has the kind of like conception of a nurse being that kind caring person who is just lovely and everyone thinks nurses are these well - most of them are these kind of like, really lovely beings - but then as you actually go into nursing I think you have a realisation that although you have to be like that, you have to have quite a lot of good time management, quite a lot of other skills as well' **P4**

'there is some lovely nurses that you meet in practice and some that you do just think, why are you a nurse ?' **P5**

One focus group participant appears to recognise that individuals may alter their attitude over time by stating,

'But if you're basically a caring person that wont change you towards your patients – relatives - but life can also change you as well' **Focus Group**

The focus group participants appear to acknowledge the dissonance between the perception of all nurses needing to be caring and the reality, or an attempt to explain the lack of caring on the reality of providing nursing care, with examples such as,

'if you're a true nurse it won't change over the years, but nursing can change you from when you start as a student and you finish' **Focus Group**

'You can become quite cynical and it's the pressures as well' **Focus Group**

I was interested by the fact that while a lot of discussion from both the student participants and focus group members related to the importance of caring by and in nursing, there was no reference made or discussion about how caring could be taught or learnt. There was a suggestion that caring was an innate quality by some students, for example;

'.... you can just pick that up straight away and you can see which ones the patients like more and which ones relate to the nurses and the.... I think it's interesting when there's certain nurses that know patients by their bed number and certain that know them by name' **P5**

In their paper, Ousey and Johnson (2007) explored the ward culture and concepts of caring to understand how they affected nursing students becoming 'real nurses'.

Interestingly Ousey and Johnson (2007) argued that,

'caring is central to nursing and each nurse would, no doubt, claim that they are a caring person' (p.152).

My results would support this claim given the strong use of the term 'caring' by both the student and registered nurse groups. The conclusion drawn by Ousey and Johnson (2007) was that in order to become registered nurses, students need to understand the two major issues of caring and clinical / ward cultures. The solution proposed in supporting students' to achieve this goal was that, 'practitioners and academics must work in unison when developing curricula and the content of these must be cascaded to the ward staff to ensure that they understand the learning needs of students'

(Ousey and Johnson, 2007) (p. 154)

Having identified caring as core element of good nursing the following sub theme explores the relationship between good nursing and the participants' explanations of competent and professional nursing.

Recognising good and bad practice

It was interesting to observe that the student interviewees could describe good and bad care and felt they could discriminate between the two.

'I think you see bad practice and I have seen it and I've seen it and have said I don't want to be like that' P2

'I think it's 'cause you meet so many different nurses that do things their way and you know everyone does it different it's just .. you know it's not right or wrong' P1

'so I think when you're in placement you can see which ones are good and which ones aren't so good and you can just pick that up straight away and you can see which ones the patients like more and which ones relate to the nurses' P4

'yea you can tell by their personalities so I think when you're in placement you can see which ones are good and which ones aren't so good' P5

Participant five talked about a specific experience she had of observing poor practice in caring for dying patients and how she was concerned that she would replicate this practice because she had not observed good end of life care,

'I really wanna sort of improve because I've seen really bad practice in like inexperience and it really scares me that when I come out of university I'm gonna think oh my God what, what if somebody dies, I will have to tell their family because what I have seen' P5

Learning from the negative

Student participants were able to describe experiences that were not positive, however they could also discuss how they turned those experiences into learning, such as;

'and then you see the bad practice and you think right .. I do not want to be like that that.... that's not what a nurse should be so you find a balance P2

'you have to make the best out of a bad situation' P2

'I just do what I can to pass and you know' **P1**

' ... Not to be like her (laughs)I think the more people you meet as well the more your views change because you pick up on different characteristics that you want to have or that you don't want to have or don't want to be like' **P4**

'there's no other feedback, like there's been, oh you need to work on this but then they're quite quick to tell you when you've done something wrongbut at the end of the placement they don't say what you can work on even though they've pointed out you've done things wrong I think that's in life, I don't think you get much positive feedback from anyone really ... I think it's quite, you just have to give yourself that I've done a really good job (laughs)' **P4**

'just experiencing those kind of things kind of builds you as a nurse but also as a person like' **P3**

'I think you get more nicer nurses it's just a shame that the horrible ones sort of stick out and it sort of you know... cause if you have a really bad day you think oh - you know you don't feel that good, where as you might have a good few weeks and one day might set you back' **P1**

'you have to make the best out of a bad situation, like I tried to go out on lots of places and be with teams that actually wanted to have students' **P2**

The research by Pearcey and Elliott (2004) echoed this theme in their findings, with learning from the negative as one of the aspects their student interviewees described when discussing negative and positive experiences of clinical learning.

Competency and professionalism described as good nursing

Given the extensive debates in the literature about competency, that the student participants did not provide particularly detailed descriptions about the qualities and abilities nurses needed to be competent and professional. In the main the concept of boundaries was identified and professionalism appears to be

associated with a detachment from patients. For example when asked about the qualities a nurse needed to be competent and professional the student participants responded with;

'need to know your boundaries' **P1**

'know where the barriers sort of is for the professional' **P2**

'you need to be professional in your manner' **P2**

'as well as being sort of jolly and happy and friendly and having a relationship with your patient you also have to do your job properly' **P3**

'they can separate professional from personal but they have this kind of like banter line' **P4**

It would appear from the student participants' responses that competence as a concept is not particularly easily articulated or is perceived as part of the overall abilities and qualities that a 'good' nurse demonstrates. Professionalism seems to be perceived as the line between maintaining friendly, caring relationships with patients while maintaining a clear boundary between the individual and the nurse.

This statement may reflect the argument made earlier in **chapter two** (page 71) about practitioners' inability to articulate core aspects of their role since they, 'do not necessarily take their own knowledge seriously, leaving it mostly untapped and known only to she/he who holds it'

(Loughran et al., 2003, p. 853).

While there has been extensive debate about competence in the literature, within my case study the concept of competence and professionalism were very much viewed as aligned and part of good nursing. The student participants' were able to discuss and describe 'good nursing', however this appeared to be due to their inability to describe nursing using competency as a framework.

NMC Competency Framework

While my interview questions were not developed to account for or reflect the new NMC (2010b) competency domains, I decided to review the student interview responses against the domains to support my analysis in relation to these professional standards. Overall there were examples where the student participants demonstrated awareness and knowledge that reflected the new NMC domains. This alignment to the professional regulators framework suggests that the student participants were credible interviewees and the responses provided were within a professional context. There is of course the potential risk that the students were providing learned 'correct' answers. The next section discusses each of the four NMC domains with examples drawn from the interview transcripts. Each of the four domains is taken in turn and will overview the key words identified for each domain. The first domain discussed is professional values.

Domain 1 - Professional Values

Student participants I believe from an analysis of key words used, demonstrated awareness of professional values. The students mentioned concepts such as, caring, confidentiality, maintaining boundaries, honesty and trustworthiness.

Diagram nine on the next page details the recurring and common terms used that were categorised as indicating professional values.

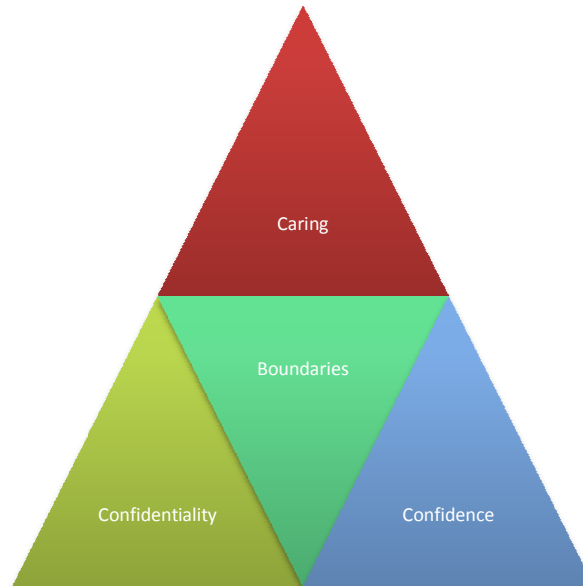
Some examples from the student interview transcripts that captured the use of these key words when describing professional nursing for example are;

'someone who actually does care, confidentiality, need to know your boundaries'

P1

'someone who is approachable, honest responsible, professional, trustworthy nice but also hardworking and professional' **P3**

Diagram Nine – Key words used to convey the NMC (2010b) competence domain of *professional values*



I was interested by the fact that professionalism was seen as a form of detachment, and the term boundary was used. I found the understanding of professionalism to be somewhat negatively perceived, for example,

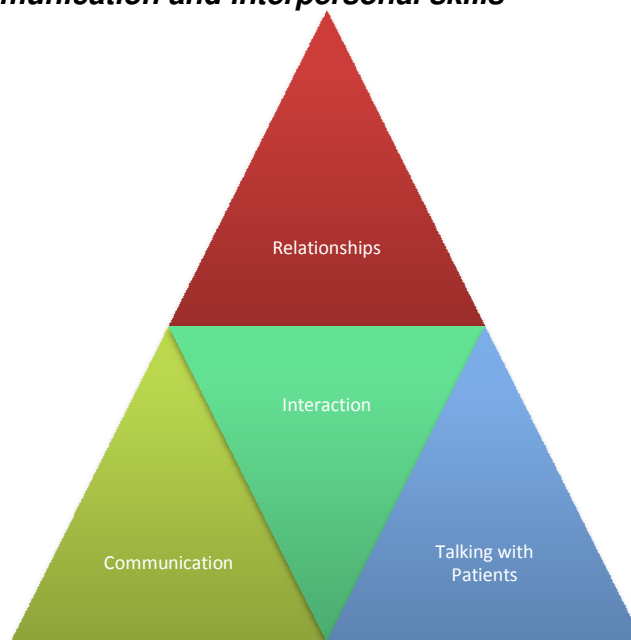
'... by being professional and being professional about it and like in some certain situations you might need to be more authoritative than in others' **P3**

'you've gotta know the boundaries, so with patients if you started like, if not..... I'm gonna say too much touching, that's not what, you have to maintain those boundaries and patients need to know that you, that there is a boundary and not to step over it' **P5**

Domain 2 - Communication and Interpersonal Skills

Again, the student participants highlighted aspects of communication and interpersonal skills as important to nursing practice. Words such as interaction, communication and relationships were used throughout the student interviews. The recurring key words identified from the student transcripts are outlined in **diagram ten** on the next page.

Diagram Ten – Key words used to convey the NMC (2010b) competence domain of *communication and interpersonal skills*



Some of the examples that demonstrate the context that the key words were used in include;

'.... relationships and things you know you don't know with your mentor with staff and patients that obviously 'cause that can't be taught can it ... different patients and people that you meet' **P1**

'Communication, not just working ... you interact as well' **P2**

'.... having a relationship with your patient' **P3**

Domain 3 - Nursing Practice and Decision Making

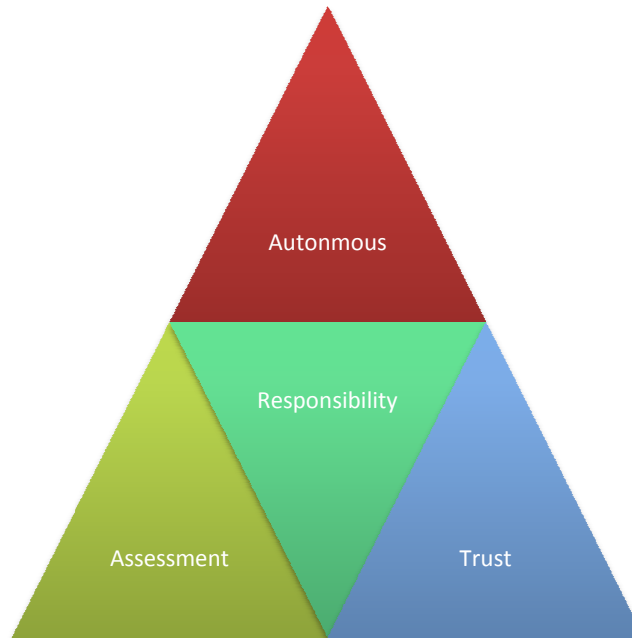
This NMC competency domain was the one that had the least examples across all participants, however when key words were identified they were appropriate and terms such as, responsibility, autonomous and holistic patient care were used by the students. Some of the examples drawn from the transcripts include;

'I feel a lot more responsible and autonomous' **P3**

'.... you're on your own and you have to perform' **P3**

'.... make assessments that are holistic to a patient' **P4**

Diagram Eleven – Key words used to convey the NMC (2010b) competence domain of *nursing practice and decision making*



The limited examples from the student transcripts in relation to this domain may be related to the inability of the participants to articulate their nursing practice.

Domain 4 - Leadership, Management and Team Working

There were some strong examples of key words and experiences described by the students that suggested an awareness and knowledge of this NMC competency domain. One student discussed time management and there was some recognition of the influence of local ward politics and use of delegation as part of the nursing role.

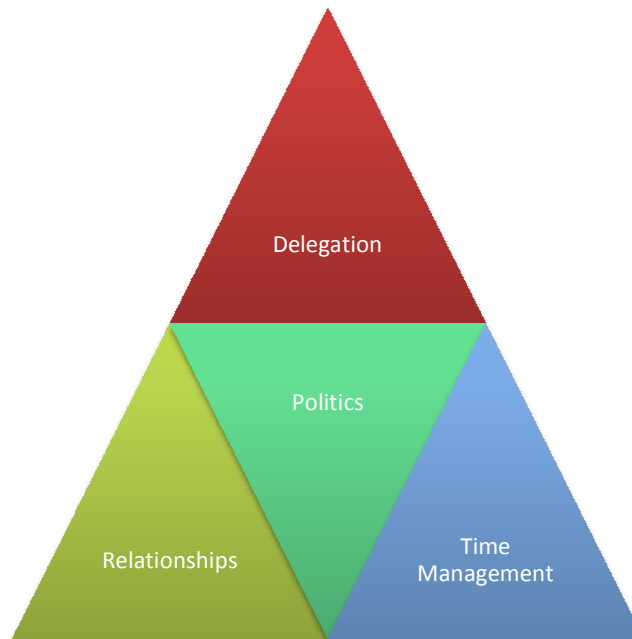
Some of the examples from the transcripts that illustrate the use of the key words identified included;

'.... like the politics and things I think you don't realize and I didn't know what uniforms meant and who was sort of the top dog' **P1**

'a sister I've just worked with didn't have the communication skills and I think went about her contact in completely the wrong way because she sits in an office all day and she directs everybody that actually in the wrong way because she

probably hasn't been there for a while' P2

Diagram Twelve – Key words used to convey the NMC (2010b) competence domain of *leadership, management and team working*



'Even though you have to be a professional you can't do your job well unless you have that relationship with the patient' P3

'.... that's what I mean by being professional and being professional about it and like in some certain situations you might need to be more authoritative than in others and you've still got to be able as being a nice person' P3

'I think the knowledge and skills that you have in the background if something was to go wrong or something was to, I don't know you find a pressure sore or something .. the nurse the registered nurse has the knowledge the competency and ability to act upon that whereas the health care assistant might not and responsibility as well sort of divides' P3

Chapter Four Conclusions And Summary

This chapter has presented my analysis and interpretation of the data generated by the student interviews and focus group with registered nurses. Through the use of coding using key words based on my research question and the components of a social theory of learning, I generated four key themes and a further sixteen sub themes. Further analysis using the four NMC competency domains suggested that students in my case study demonstrated some experience and knowledge that aligned with the four new NMC competency domains. However, evidence of understanding professional values, decision making and leadership and management were limited given the overall articulate nature of each student.

Diagram thirteen on the next page identifies the three elements arising from the research question, ***Becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

My research study findings suggest that nursing student learning is influenced through interaction with others in the clinical environment. The influence on student learning is mediated through interaction with others (frequently mentors) who by their responsiveness to students' learning needs motivate and support them to identify and observe nursing care undertaken by others. Interaction with others when welcoming and engaging creates a sense of belonging for students, which students report as having a positive influence on their learning.

This need to belong would appear to continue as part of the transition to registration. In a recent paper, researchers identified the strong need for Australian newly qualified nurses to 'fit in' with their new working environments and colleagues (Malouf and West, 2011).

The researchers concluded that newly qualified nurses

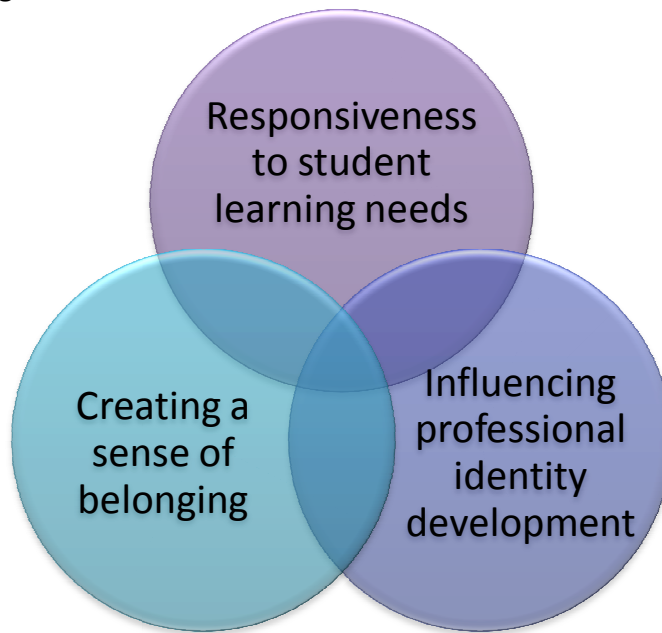
'.... instinctively understood the benefit of establishing solid social relationships and actively tried to avoid the ill effects of not having at least minimal social ties

within the workplace that they were entering. Fitting in was a very important feature of 'becoming' a RN (Malouf and West, 2011, p. 492).

This finding while supporting my findings would suggest that the significance of learners having the ability to engage and belong to established clinical teams is important beyond their role as students and part of their ongoing professional career development.

Through observation and role modeling, others can influence student professional identity development by providing positive examples of good nursing. Equally, students can distinguish between good and bad nursing and when others demonstrate a nursing approach that students do not consider appropriate or good, they actively choose not to replicate this behavior or care. The student participants wanted to actively manage their learning and sought responsibility and trust for doing so. The student participants described how they were able to observe and develop their nursing practice; what they described as the 'tricks of the trade' and more importantly I believe; the 'little things that matter' – aspects of nursing that the students perceived as 'good' nursing. These descriptions of learning indicate that students did not experience learning in the clinical environment as passive receivers of knowledge or simply a replication of observed actions. The student participants were able to describe an ability to discern differences in the nursing practices they witnessed and actively selected from their experiences to become the nurse they wanted to be.

Diagram Thirteen - The three influential elements of interaction with others on learning



Despite the focus on competence frameworks and awareness that their placement learning outcomes were captured in the continuous assessment of practice documentation, the student participants in my study provided a very limited description of competence and professionalism. Professionalism and competence tended to be described as 'good' nursing and frequently 'good' nursing was aligned to 'caring'. The over reliance on caring as a proxy description of nursing is a concern and this aspect of my findings supports the conclusions reached by Papastavrou et al (2011) in their systematic review of differing perceptions of care and caring. Importantly the review argued that currently there is no accepted definition of what constitutes care or caring behaviors or actions believed to be caring by care givers are not always perceived as such by patients or recipients of the intervention (Papastavrou et al., 2011). Given the reliance by both student and registered nurse participants in my study on explaining and describing nursing as 'caring' the disparity between care receiver and giver perceptions identified by Papastavrou et al. (2011) may provide some explanation for the current tensions and concerns about the standard and quality of nursing care. The overreliance on

the term 'care' and an inability to articulate actual nursing intervention and therapy may be one possible reason why nurses have reportedly failed to provide the levels of interaction and fundamental human needs such as providing fluids, feeding and assistance with toileting.

Neither the student or registered nurse participants in this study provided a detailed description of the essence of nursing, however the students did all appear to have defined their own standard of 'good' nursing and admired and sought to replicate the actions of the nurses they believed reflected their own image of nursing.

Learning in the clinical environment was described by the student participants as providing unique learning opportunities to gain skills, knowledge and experience of 'real life' nursing. Part of this 'real life' experience related to time pressures and the need to prioritise actions. The student participants were able to describe a number of learning experiences that they believed could only be facilitated in the clinical environment, indicating the importance of clinical experience to their learning.

In terms of identifying learning opportunities in the clinical environment, it appeared that having successfully completed the majority of their course, the student participants in my study, were adept at identifying potential learning opportunities from their allocated clinical placements. Generally feedback from mentors was used as the main source of guidance on how well they were performing and progressing. However, feedback appears to only have value when provided by a registered nurse the students admire and respect. This finding supports the need for mentors to be exemplary and respected clinicians if the mentor role is to have the intended impact on student learning that is expected. There was recognition from the students' that other health care professionals also influenced their learning through contact, however the influence of nurses, in

particular mentors was described as most influential by the student participants in my study.

The central nursing theme throughout my study has been patient safety and a recent report exploring how to improve nursing care for adults receiving hospital care was undertaken by Sawbridge and Hewison (2011). The report was of particular relevance to my findings in that the study specifically looked at nurse education as part of three areas of action including;

- 1 . Environment of care
2. Education and development and,
3. Emotional labour of care.

This report is of additional relevance since the study participants were senior nurse leaders and directors within the region where my study was undertaken. The central recommendations from the report (Sawbridge and Hewison, 2011) argue for a recognition of strong clinical leadership at ward level from registered nurses selected for their appropriate attitudes and competence acting as,

‘.... the linchpin of good patient care’ (p. 4)

acting as role models, influencing colleagues.

The key recommendation for nursing students was the need for them to,

‘.... feel a greater sense of belonging to the nursing profession rather than being identified primarily as a university student’ (p. 4)

Sawbridge and Hewison’s (2011) timely report supports some of the findings from my own study, the importance of strong role models in the clinical environment and the need for learners to be supported to have a sense of belonging to the clinical team and the wider context of nursing as a profession.

Elements of my earlier diagram three (page 45) such as ‘safety to practice’ and ‘safety to learn’ combined with the learning experiences within the clinical environment were reflected in a recent paper examining the use of the ascent to

competence conceptual framework (McCoy et al., 2011). The researchers suggest that their developed psychometric test provides an approach to measuring nursing students' perceptions of the quality of their clinical placements (McCoy et al., 2011). The development of such an assurance / measurement tool provides opportunities to raise the importance of belongingness and valuing of individual students within a safe learning environment for students as a key prerequisite to achieving clinical safety and competence.

The findings from my study are now applied in the following and final chapter to make recommendations of ways in which the nursing student experience of learning from others in the clinical environment may be improved and enhanced.

Chapter 5 – Implications Of Research Findings For Professional Practice

Introduction

This final chapter of the thesis is structured in three elements. The first section discusses the implications for practice based on the findings and recommends:

- 1 - strategies for registered nurses and nursing students and,
- 2 – content areas for audits and evaluations of clinical environments.

The focus of the chapter then shifts to critique the overall research project using a framework proposed by Denscombe (2002). Finally, the summary and conclusion of this chapter identifies possible future research opportunities building on my work to date.

Implications of My Findings – The Gaps in Current Practice

My study was concerned with exploring and describing the learning experiences of nursing students in the clinical environment with specific focus on the influence of registered nurses on their learning. My findings support and build upon the existing literature in supporting the potential influence of registered nurses and others in the clinical environment on enabling and supporting learning. The new and unique contribution to knowledge from my work is reflected in the detailed descriptions of student experiences. From the analysis there is evidence that the student participants in my study wanted to be and were active participants in their learning and that they constructed and managed their learning to become the nurse they wanted to be; rather than passive observers and receivers of information and skills. Registered nurses had a significant impact as role models in creating the image of nursing that students held. 'Good' nurses were admired by the student participants and were perceived as being able to communicate and demonstrate the 'tricks of the trade' and more importantly their nursing practice through the 'little things that matter'.

Equally while my findings have illuminated the active participation of students in their learning, there was recognition of the negative impact of certain blockers that can exist in clinical environments. Key blocks to learning were clinical staff that did not actively engage and support students. Any lack of engagement was further damaged when students were not supported to be part of established clinical teams, reducing a sense of belonging by the student and creating feelings of not being respected or valued. As an example, the failure of clinical staff to learn students' names was cited by the participants as a simple yet very demotivating experience.

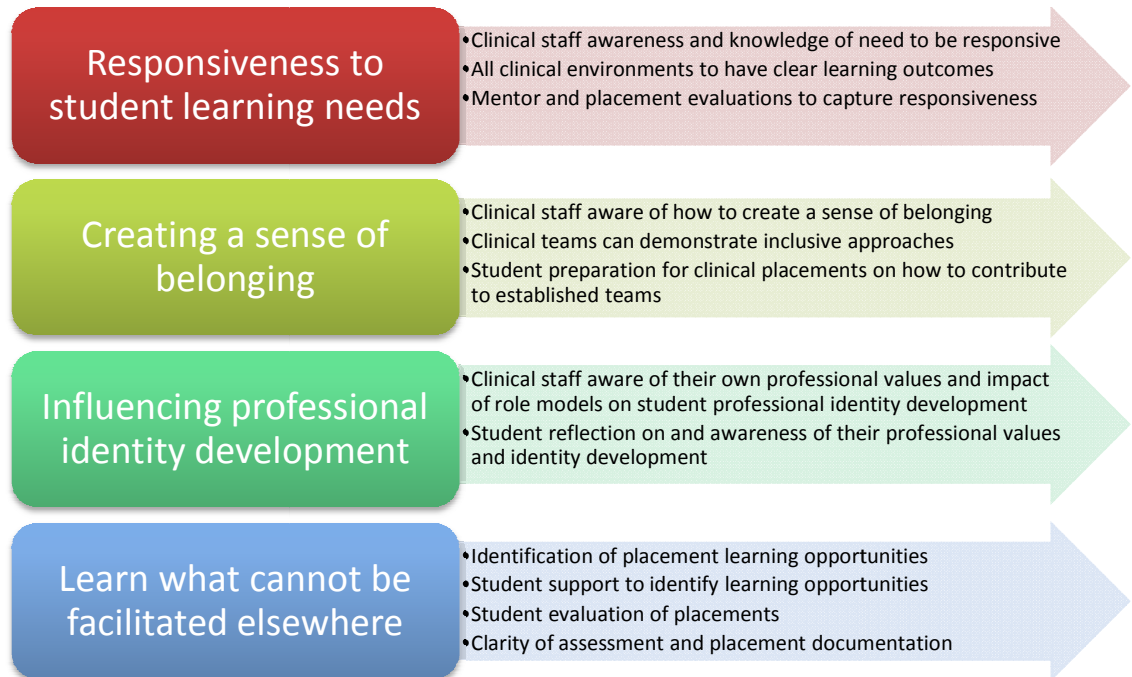
Registered nurses who participated in my focus group did demonstrate awareness of the need to include students within clinical teams and to actively support learning. However, reflecting previous studies; pressures of clinical work load, paperwork, lack of clarity about student learning outcomes and need to 'get the job done' were cited by the nurse participants as reasons why learning in the clinical environment was not always supported. The student participants were also unclear at times about what the specific learning outcomes were during some placements. It was apparent from the analysis of the interviews and focus group data that while a competence framework is used within nursing education, the term and concept of competence remains unclear. The anxiety and lack of clarity around learning outcomes is due I suggest to the inability of either the students or registered nurses to articulate and describe 'nursing'. Consistently the participants in my study defaulted to using the term 'caring' to describe nursing. It would seem that nursing and the unique contribution of nurses was only recognised when witnessed or experienced by the participants in my study.

Through the use of semi structured interviews I was able to gain an understanding and insight into the lived experience of a group of five nursing students. The richness in data afforded by my approach has provided new and additional

understanding into the complexity of how learning is supported in the clinical environment. While my findings support previous studies, my work should be valued for the richness of experience captured from a specific group of learners at a time when nursing and nurse education was undergoing change and significant criticism for failure to provide the level of nursing that was considered by many to be acceptable.

The findings described above are applied and used as the basis for a number of recommendations and approaches that recognise the influence of registered nurses (in particular mentors) on nursing students' learning in the clinical environment. **Diagram fourteen** presents the broad implications for practice arising from my research. The implications are grouped into three sets, reflecting the nature and relationship between the clinical environment, clinical staff and nursing students. Firstly mentor and clinical staff education and needs are discussed, followed by student education and preparation, and finally audit and evaluation of the clinical learning environment. In discussing implications of practice I was mindful of the complex arrangements in terms of those involved and responsible for UK pre registration nurse education. Where there are suggestions for mentor and clinical staff education, there will need to be engagement with individual practitioners, their employers and the relevant education provider.

Diagram Fourteen – Four Key Findings and their Implications for Practice

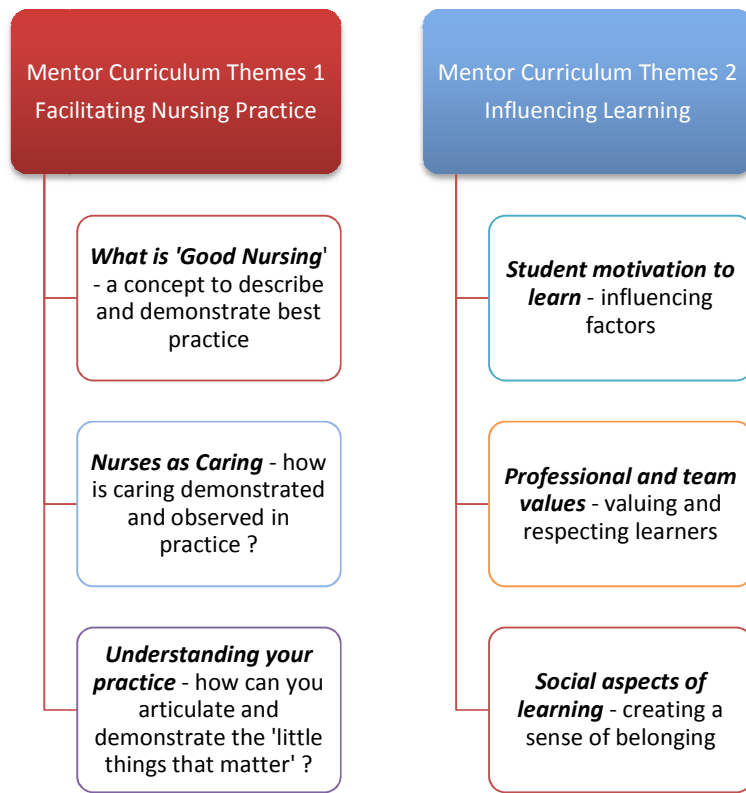


Implications for Practice One – Actions to support registered nurses

Registered nurses and mentors have a significant role to play in supporting and influencing student learning in the clinical environment. Three of the four themes require education and awareness raising for registered nurses. Through their responsiveness to student learning needs, clinical staff have the potential to improve the learning experiences of students. As highlighted earlier in **table nine** (page 117), the themes identified in my work relate to the existing NMC (2008) standards for teaching and assessing in practice. **Diagram fifteen** on the next page provides an overview of the content and focus that could be introduced or included in existing mentor preparation and update courses. The suggested six areas for exploration (curriculum themes) with clinical staff challenge the commonly used phrases by the student and registered nurses in my study, such as 'good' nurses and 'caring'. The six areas also highlight the dual nature of the clinical environment as a workplace providing nursing and also as a learning environment and would require registered nurses to consider their practice and how they can describe what they do and how this could be conveyed in the most effective way to others.

I recommend that mentor preparation and update courses (if not already doing so) should challenge participants to consider 'good' nursing and what this means to them. This should then be built upon by the exploration of caring as a concept to describe nursing, ultimately leading to facilitating an exploration of how clinical staff describe their practice and support them to describe their 'tricks of the trade'. The second set of curriculum themes seek to develop mentor and clinical staff awareness of the importance of relationships and the sense of belonging needed to support learning.

Diagram Fifteen – Implications for Practice One : Actions to support Mentor Curriculum



My research has supported the concept of 'good nursing', which is also applied within the literature. The study (Morris, 2010) concluded that the overall desire and expectation from the public and nurses of nursing and nurses was ensuring that, '.... front line staff had the knowledge and skills to provide good care ' (p. 19) a sentiment that takes this final chapter in many ways back to the beginning of this thesis.

In essence the six curriculum themes should lead towards and focus on influencing professional identity development. The development of a professional identity, I believe is key in allowing nursing students' to become a nurse. Wenger (1998) stated that,

'.... the concept of identity serves as a pivot between the social and the individual, so that each can be talked about in terms of the other' (p 145).

Based on my research findings there are examples where students needed to be recognised as individuals in a social context – ‘names are important’ and wanted to be welcomed into the established team and given responsibility and trust. Equally the students described becoming a nurse and discriminated between the kind of nurse they did or did not want to be. I would suggest that my research supports the tension that exists for learners and clinical staff supporting learning and evidences Wenger’s (1998) claim that,

‘.... practice entails the negotiation of ways of being a person in that context’
(p.149)

As final year nursing students the participants in my study are likely to have successfully developed the skills to be able to ‘negotiate ways of being a person’, as individuals, learners and fledgling nurses. As a natural progression, the next section of this chapter explores the implications for learners.

Implication for practice two - Actions to support nursing students’ learning in the clinical environment

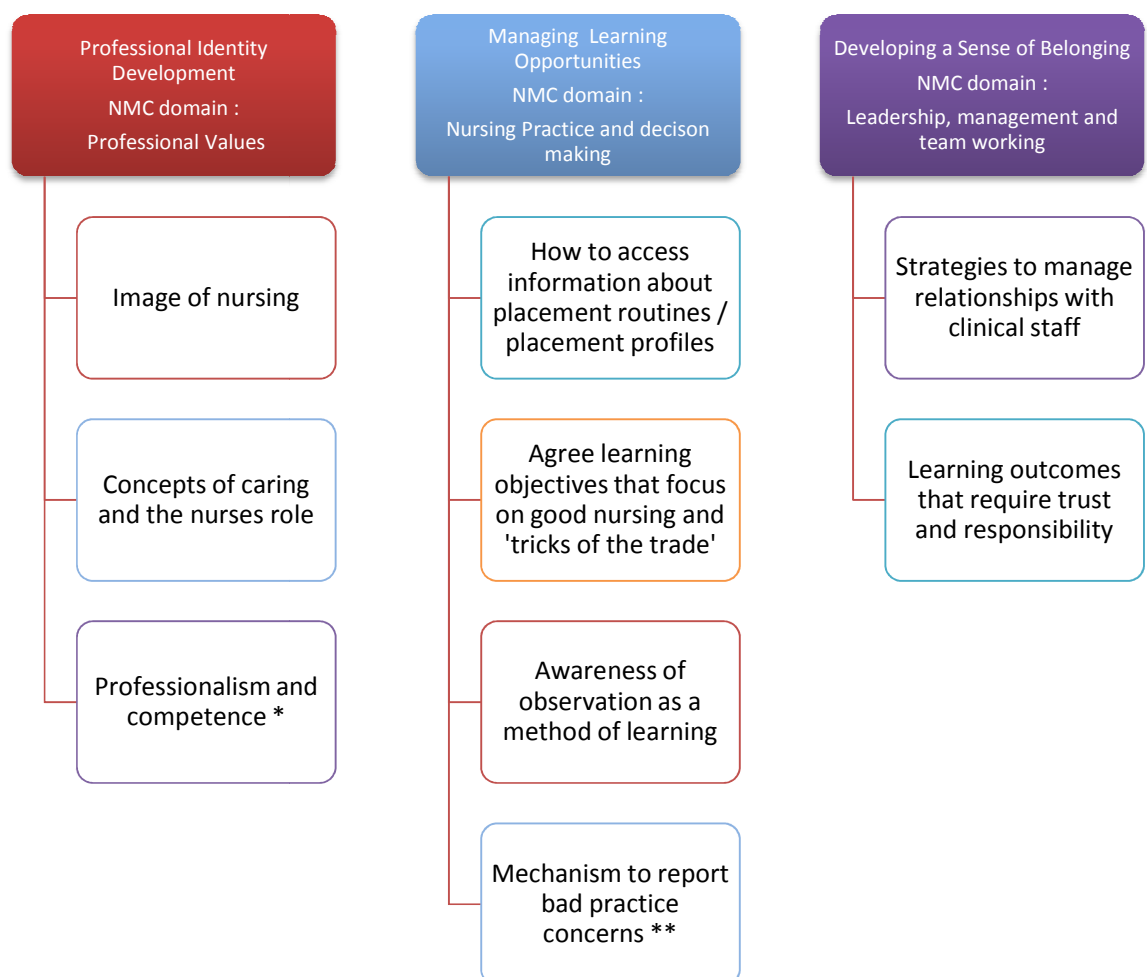
In considering the implications and impact of my research on supporting nursing students, I have created three sets of suggestions for approaches that may support learning in the clinical environment which are; professional identity development, managing learning opportunities and developing a sense of belonging (**diagram sixteen on the next page**). These three areas resonate with the three aspects of legitimate peripheral participation discussed in chapter one (page 39). Given that the NMC competency domains will soon provide the framework for nursing curricula, I have aligned three of the domains to the three sets of actions for students.

The first set of actions for students is intended to support students to consider the type of nurse they wish to become and how their professional identity is created.

This activity relates to Wenger's (1998) view of legitimate peripheral participation supporting the newcomer's identity development as a member of the community.

The concept of caring appears to be applied by students and registered nurses as a means of describing nursing practice and as such acts as a 'short hand' description of a range of nursing activities and practice. In supporting students to be able to understand and describe their practice in more detail students should be supported to explore a wider range of concepts such as 'good nursing' to form their professional values and allow for a stronger articulation of what constitutes safe and competent nursing.

Diagram Sixteen – Implications for practice two : Actions to support nursing students' learning in the clinical environment



Supported by *The code* (NMC, 2008a) ** Supported by *Raising and escalating concerns* guidance (NMC, 2010a)

The second set of activities for students' focuses on how learners can be supported to effectively manage their learning opportunities in the clinical environment. The suggested actions support Wenger's (1998) view of legitimate peripheral participation supporting newcomers' to progressively and increasingly engage in complex activities.

The final set of actions are intended to support nursing students to be able to engage with clinical staff to manage their role in developing a sense of belonging. These actions relate to Wenger's (1998) view that legitimate peripheral participation enables newcomers' to enter the world of the 'old-timers'.

Audit and Evaluation of the Clinical Learning Environment

In recognising the rotational nature of nursing placements, **table ten** provides education providers and clinical teams with a selection of suggested questions that should be used as part of placement quality reviews and student evaluations of learning. While recognising the potential limitations of post experience evaluations by learners, the suggested questions do provide a focus that attempts to draw out and focus attention on the areas identified in my research as influencing learning.

Table Ten – Potential questions for placement audit and student evaluations

<i>Placement Audit Evidence</i>
1. Is a current placement profile available detailing learning opportunities ?
2. Is information available detailing the ward / clinical area daily routines ?
3. Are students supported and allowed to have a patient case load ?
4. Has the clinical team developed a set of team values and if so - do these reflect the contribution and needs of learners in the team ?
5. Are nursing staff able to articulate their nursing practice ?
6. Are staff able to describe and demonstrate that they are responsive to student learning needs ?
7. Are clinical staff able to describe how they support professional identity development of learners ?

Student Placement Evaluations

1. Were you known and addressed by your name?
2. Do you feel you were trusted by the clinical team ?
3. Were you given appropriate levels responsibility for managing patient care?
4. Did you have the opportunity to observe and participate in interactions and communication with patients and relatives ?
5. Did the placement profile accurately reflect the actual learning opportunities available to you ?
6. Did you have opportunities to observe patient care provided by expert nurses ?
7. Do you consider the care provided by the clinical team to be good ?
8. Were nursing staff responsive to your learning needs ?
9. How has this placement experience supported your professional identity development ?

Personal Reflections and Critique of the Research Method and Process

In the introduction to this thesis, I described my research style as a ‘real life’ approach, based on Robson’s (2002) description of such a style as, ‘... seeking to say something sensible about a complex, relatively poorly controlled and generally ‘messy’ situation’ (p. 4)

As I progressed through my work, I was overwhelmed at times by the complexity of my study topic, which I found to be a ‘messy’ situation. My refinement and eventual focused research question allowed me to construct a framework to contain the numerous elements I identified while representing the relationship between those aspects of my research (**diagram three** - page 44).

The use of case study provided me with a flexible approach and on reflection, with greater time and the lack of a word limit I would have included other sources of data to fully capitalise on the case study method. I would have liked to have undertaken a documentary review of the participants placement records to review

key words and phrases used by students and their clinical assessors (mentors) to describe their agreed learning outcomes and records of achievement. Near the end of my research I became aware of the increased use of reader comment sections of professional journals and believe that reader comments could provide another useful source of data about learning experience. I am also mindful that other participants could have provided perspectives on my area of study such as university lecturers and newly qualified nurses.

In recognising that my case study examined a specific group of learners' experiences, my implications for practice acknowledge that in many cases education and placement providers may already be taking the approaches I suggest. However, the following approaches have been developed as a result of my work and where implemented, their effectiveness in improving learning experiences would be need to be evaluated by those introducing any changes.

Denscombe (2002) identified ten key elements that were presented as a 'check list' of areas to consider; purpose, relevance, resources, originality, accuracy, accountability, generalisations, objectivity, ethics and proof. I have used each of these ten terms to assess the quality and ability of my research to be externally critiqued.

The first challenge Denscombe (2002) presents to social researchers is to demonstrate clarity of purpose of their work. As part of defining the purpose of my work I asked myself if my work was worthwhile ? I would argue that the work provides a significant contribution and has a purpose since it was concerned with understanding the experience of learning in the clinical environment. My work has produced a number of themes that help to describe and understand the learning experiences of the student participants in my case study. The motivation to undertake this research was driven by a desire to improve the learning experiences of nursing students with the eventual and ultimate aim of improving

the quality of patient care. Concerns about the quality of nursing care and caring are contemporary and this I believe gave my work particular purpose in understanding nursing student learning from a safety standpoint.

The second rule that Descombe (2002) asks researchers to consider, is the relevance of their work, or what is to be gained from the research ?

The relevance of my work is linked to the purpose. As outlined in chapter one, concerns about the education and preparation on nursing students with the resultant quality of nursing provided gave my work particular relevance at this time. With at least half their learning taking place in the clinical environment, there is a significant amount of resource invested in supporting nursing students with their clinical learning and any study that helps and supports understanding of how to effectively make use of this time is relevant to improving the educational experience of nursing students. In the context of the current literature reviewed my work is relevant in that it supports findings from earlier studies and also introduces new concepts and themes.

The third area to be considered is resources and the researcher is challenged to ensure that the work is feasible and can be completed on time. As a part time researcher I did underestimate the scale and challenge of undertaking this study while in full time employment. I was at stages, overwhelmed by the literature, understanding the nature of my research question and management of the data collected. Part way through my research I needed to extend the study time by an additional year. As a novice researcher, the need to extend my research time was a consequence and much of the early time of my work was protracted as I revisited and adjusted my research question and focus. My learning from this experience is the need to spend much more time at the outset, understanding the nature of the research question and defining a much more specific research

question at the early outset. I have also found the use of frameworks a useful means of giving 'shape' to my thinking and providing structure.

Originality is the next consideration and I believe my work provided originality in terms of my focus on the interaction of others and their influence of others on learning. While other studies have explored the qualities and experiences of mentors and learning in the clinical environment, my work is original in the focus of the interview questions that were developed from the existing literature. I also consider my three-stage approach to analysis of the transcripts providing an original perspective on the study topic. Given the recent publication of the NMC (2010b) competency domains my work is likely to be one of the first or forefront pieces of research to use the NMC domains as a method of analysis. My work has applied the new NMC competency domains to current student learning experiences, providing understanding of how the domains reflect current student experiences, reflecting another area of originality.

For the fifth consideration, Denscombe (2002) asks researchers to defend the accuracy of their data. I consider my data to be accurate because I made digital recordings of the student interviews and focus group. The content of the interviews were captured through the use of verbatim transcripts that were returned to participants for checking and comment. Once I had developed initial themes from analysis these were reviewed against existing literature. Throughout my reporting I have used actual participant comments to allow transparency to assure accuracy and non-distortion of the data in analysis.

I would suggested that one of the more robust challenges to demonstrating the accuracy of the results of a study are to present the findings to peers who are best placed to critique and challenge any findings. As part of my commitment to sharing my findings with my professional peers, I have presented the results of my research in the format of a poster presentation (O Luanaigh, 2011) to a National

professional health care conference. I also intend to submit a paper to a peer reviewed journal detailing my research and findings. This sharing of my work will allow others to comment on my findings and indicate their support and query my work.

Accountability is the next area Denscombe (2002) challenges the researcher to question why a reader should believe their research results ? I believe through my faithful presentation of data and use of direct quotes from the interview and focus group transcripts allows the reader to have full access to the material on which my analysis was based. I have also provided the detail of the process I applied in developing my key and associated themes.

While Denscombe (2002) talks about generalisations as the seventh rule, I argue that it is more appropriate to discuss transferability in the context of my work. In considering the transferability of my findings I thought about the extent that the results could be expected to apply more widely. Given the resonance of my results with the existing literature the potential generalisability and transferability of my findings are strengthened. I am mindful however of the sample size of five participants and the potential of differing views and responses that may have been obtained from respondents from different age groups and academic ability for example. In considering attitudes and views on caring for example, I also note that these perspectives may be influenced by gender and cultural differences. However, the case study approach allowed me as a researcher to gain an in-depth understanding of a specific sample group.

Objectivity in my work was supported by having a research question that I kept as the central focus as I progressed my research. Throughout my work I was mindful of the need to be impartial and reduce any bias in my decision making or analysis. I made use of coding and record keeping to provide an audit of my decision making. Objectivity was also achieved I believe through my discussions with and

challenge from my supervisor on a range of assumptions and arguments I proposed. Equally in the later stages of my work a further critique of my work from professional colleagues forced me to justify and support my position.

In considering ethical considerations, the section in chapter three (page 89) detailed my approach to conducting my work in an ethical way. This element of my work was as stated earlier structured using established guidelines. Throughout my preparation, data collection and thesis writing I have been mindful of the need for data security and the maintenance of confidentiality.

Finally, Denscombe (2002) asks researchers to consider proof. To have relevance to my research method, proof arises from my enquiry rather than as a result of meeting any external truth or law for example. The 'proof' in my work is evidenced through the support for my findings and resonance from existing literature as discussed in chapter four. Confidence in my work is also supported through my use of established theory (components of social learning) and a regulators framework (NMC competency domains) to analyse my results.

Thesis Summary and Conclusion

Through analysis of nursing students' descriptions of their experiences and the accounts provided by experienced nurses my research has provided new understanding; supporting the important role that registered nurses have in influencing learning in the clinical environment.

The review of my work using the ten ground rules for research (Denscombe, 2002) demonstrates that my work was undertaken in a responsible, ethical, honest and purposeful way.

My implications for practice are focused in the main on educating clinical staff and raising their awareness. The next stage of my post doctoral work could be to audit and review the curricula for mentors across UK institutions. There is also value in

exploring how nursing academics could best support mentors and nurses to develop and become effective through their responsiveness to learner needs.

My four key themes provide a framework to structure future research with students and clinical staff to explore the actual transferability of the findings from this study.

I would like to use the three themes of influence on learning to explore with clinical staff what prevents or would allow them to implement my suggestions. Finally, my research adds to the existing body of knowledge relating to clinical learning and provides further evidence of the importance of the clinical environment as providing unique learning opportunities while supporting the need to understand the social aspects of learning in the clinical environment.

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Appendix One – Identifying key themes arising from the literature relating to clinical learning

Year	Author(s)	Context	Findings	Theme(s)	Chapter Section
1993b	Giroit	Interviews with ten UK ward sisters	'Trust' – students aware of their limitations as key indicator of safety	Students knowing limits and trust as key indicator of safety to practice	Nursing knowledge
1993	Baillie	Interview with eight UK nursing students	Role of the mentor crucial for learning. Mentor knowledge and attitude towards students, their professionalism, in particular communication skills essential for effective mentorship	Mentor Role and mentor attributes and skills	Becoming a nurse
1995	Earnshaw	Questionnaire with 19 nursing students	Mentors very important in early part of programme passing on routines and norms of behaviors	Importance of mentors – routine and norms of behaviours	Becoming a nurse
1998	Nolan	Descriptive, interpretative study. Interviews with six second—year Australian nursing students – and informal discussions and observations of the participants during their placement	'I don't belong' 'doing and practising: progress at last' 'Transitions in thinking'	Need to belong 'feeling part of the team' to support learning Important role for clinical staff Students need support to transition from University to Work based learning	Nursing praxis
2000	Spouse	Eight UK pre-registration nursing students Multi-method, in-depth interviews and case studies	Student perceptions of nursing were a strong influencing factor in their deciding to continue with their course	Image of nursing important motivation to continue with studies	Becoming a nurse
2001	Spouse	Longitudinal study with UK nursing students	Relating to patients and their relatives Developing technical knowledge Learning to bundle activities of nursing together Developing craft knowledge Relating to and functioning within a clinical team Managing feelings and emotions (their own and those of patients and relatives) Developing the essence of nursing which promotes therapeutic action	How to 'be' a nurse	Nursing knowledge
2003	O'Callaghan and Slevin	Registered Nurses	Focus on 'work' and not 'learning'	No recognition of learning in the clinical environment	Nursing praxis
2004	Pearcey and Elliott	14 final year undergraduate nurses Focus Groups Why students left their course	influence of ward culture, learning from the negative mentors.	Positive and Negative Aspects of Clinical Learning	Nursing praxis
2008	Levett-Jones and Lathlean	Australian and UK Nursing Students	Belongingness was highly influential on student participants' motivation and capacity to engage in clinical learning opportunities.	Belongingness	Nursing as profession

			Regular contact with mentor significant influence on learning		
2009	Newton et al.	29 undergraduate Australian nursing students	Creating learning opportunities Gaining independence Becoming part of the team	Learning in the clinical environment Complexity of clinical learning, social, cultural and political	Nursing praxis
2009	Perry	Eight Canadian Nurses	Exemplary nurses are able to articulate their craft knowledge and have a key role in influencing quality care	Exemplary Nurses attend to the 'little' things and are effective role models	Becoming a nurse
2009	Roberts	15 UK pre-registration nursing students Observation in clinical environment	Students develop a parallel community – since on edge of established community of practice. Friendships with other students support learning 'all in the same boat'		Nursing as profession
2010	Christiansen and Bell	Focus Group with 54 nursing students who had participated in peer learning partnerships	Peer Learning	Social Isolation	Nursing as profession

Appendix Two – Ethics approval from the OU



The Open University

From Dr Duncan Banks
Chair, The Open University Human Participants and
Materials Research Ethics Committee
Research School
Email d.banks@open.ac.uk
Extension 59198

To Pádraig O Luanaigh

Subject Becoming a professional: how does interaction with others
in the clinical environment influence nursing students'
learning?
Ref HPMEC/2010/#830/1
Date 24 November 2010

Memorandum

This memorandum is to confirm that the research protocol for the above-named research project, as submitted on 24th November 2010, is approved by the Open University Human Participants and Materials Ethics Committee by Chair's Action. I notice that this application has already received approval from the two other partner institutions.

At the conclusion of your project, by the date that you stated in your application, the Committee would like to receive a summary report on the progress of this project, any ethical issues that have arisen and how they have been dealt with.

Duncan Banks
Chair OU HPMEC

The Open University is incorporated by Royal Charter (number RC 000391), an exempt charity in England & Wales and a charity registered in Scotland (number SC 038302)

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Appendix Three – Letter of thanks to student participants

Re: Research Participation

Dear <<First Name>>,

I am writing to formally thank you for your participation in my research interviews, which were undertaken as part of my Doctor of Education work.

The research question focused on how nursing student learning was influenced by others when on clinical placement. The early results from the interviews are very positive and provide a lot of useful information.

I will be working to disseminate the final results of this work with the aim of improving the quality of the clinical learning experience for nursing students in the future.

On a personal note, I was extremely impressed by your professional approach to the questions I posed and you demonstrated an attitude and motivation by engaging in this research, which I believe evidenced your personal commitment to on going professional development.

I wish you every success with your studies and future career plans.

Yours sincerely,

Appendix Four – Communication A with prospective participants

Email communication 1

Subject : Clinical Learning Research - Interviews Participant Invitation

Dear Student Colleague,

Your programme leader has sent this email on my behalf, following your University's approval of my Doctor of Education (EdD) ethics application to interview final year nursing students at XX University.

I hope you will take a few moments to read about my research and will consider participating in the project. I am a registered nurse, midwife and health visitor and currently work at NHS West Midlands Strategic Health Authority in Birmingham. I am in the final year of my Ed.D. studies with the Open University.

My Doctoral research is entitled <<Title>>

I wish to interview students in your cohort about your experiences of learning while on clinical placements. Interviews will be conducted in private and will be anonymous. I will make written notes during the conversation, which will also be recorded. The focus of the interview will be on your own personal experiences of learning and there are clearly no right or wrong answers.

Participants will be provided with a draft copy of the interview record to check for accuracy. No information will be shared about your comments with your University or placement providers. A copy of the final thesis will be sent to XX university on completion of my studies.

The interviews will last a maximum of 50 minutes.

I do hope you will consider supporting my research studies which should provide useful information and understanding which could support future nursing students.

The interview days are scheduled for <<Dates>> <<Room location>> between <<Times>>

Please email me directly by <<Final Date>> if you would be willing to participate, indicating the date(s) and time(s) you would be available.

My email contact is XXXXX

Thank you

Appendix Five – Communication B with interviewees

Email communication 2

Dear <<First Name>>

Thank you for agreeing to participate in my Doctoral research interviews.

I would like to confirm that our interview will take place on
<<Date>> at <<Time>> Location <<room>>

Please read the following important information relating to the interview:

1 – The interview will be conducted by me alone

2 – I will take written records of what is said during the interview and a digital recording will be made of the interview.

3 – You will be identified by a participant number not your name on all documentation relating to the interview record.

4 – Following the interview you will be sent via email a record of your interview and you may confirm and suggest corrections or amendments to be made to the record

5 – You may withdraw from participation in the interview at any time up to the interview or during the interview

6 – The content of your actual interview will not be shared with your university or placement providers. However, should you disclose any information which I consider in my professional opinion to potentially be harmful to you or the public, I will highlight this and provide you with information on where you can seek support from your university.

Thank you again for your support with my research. Should you have any queries relating to the interviews or my research prior to our meeting, do please get in touch.

If you are unable to keep the appointment I should be grateful if you could let me know in advance.

Appendix Six – Consent form and information sheet for student participants

Private and Confidential - Consent to Participate in a Research Interview

Thank you for agreeing to participate in an interview as part of my Doctor of Education (EdD) Research with the Open University.

The research title for the study is ***becoming a professional: does interaction with others in the clinical environment influence nursing students' learning?***

Before participating in the interview, please read the following statements and if you are happy to proceed please print your name, sign and date where indicated below.

You will be provided with a copy of this form.

This form will be kept securely in a locked file and will be destroyed by paper shredder when I have had confirmation from the Open University that I may do so, which is likely to be by December 2011.

1 – I will conduct the interview alone.

2 – I will take written records of what is said during the interview and a digital recording will be made of the interview. Access to the recording will be password protected and held on an external disc media once transcription of the interview is complete.

The recording will be deleted in December 2011.

3 – You will be identified by a participant number only on all documentation relating to the interview record.

4 – Following the interview you will be sent via email a record of your interview and you may confirm and suggest corrections or amendments to be made to the record.

5 – You may withdraw from participation in the interview at any time up to the interview or during the interview – if you do withdraw, any notes and recording will be securely destroyed and not used in the research.

6 – The content of your actual interview will not be shared with your university or placement providers in relation to identifying you personally. However, should you disclose any information, which I consider in my professional opinion, could potentially be harmful to you or the public, I will highlight this to you and provide you with information on where you can seek support from your university.

7 – Should you have any questions following the interview you may contact me by email at XXX and I will respond and /or meet you to discuss.

Please sign this form to indicate that you are happy to participate in the interview and have read this form.

Appendix Seven – Consent form for focus group participants

Private and Confidential - Consent to Participate in a Focus Group

Thank you for agreeing to participate in a focus group discussion as part of my Doctor of Education (EdD) Research with the Open University.

The research title for the study is ***becoming a professional: what is the influence of registered nurses on nursing students' learning in the clinical environment ?***

Before participating in the focus group, please read the following statements and if you are happy to proceed please print your name, sign and date where indicated below. You will be provided with a copy of this form.

This form will be kept securely in a locked file and will be destroyed by paper shredder when I have had confirmation from the Open University that I may do so, which is likely to be by December 2011.

1 – I will take written records of what is said during the focus group and a digital recording will be made of the discussion. Access to the recording will be password protected and held on an external disc media once transcription of the discussion is complete. The recording will be deleted in December 2011.

3 – You will only be identified by a participant number on all documentation relating to the focus group record.

4 – Following the transcription of the focus group discussion you will be sent via email a copy of the transcript and you may confirm and suggest corrections or amendments to be made to the record

5 – You may withdraw from participation in the focus group at any time up to the event or during the focus group discussion – if you do withdraw, any notes relating to your contribution will be securely destroyed and not used in the research.

6 – The content of the actual focus group will not be shared with your university or employer in relation to identifying you personally. However, should you disclose any information, which I consider in my professional opinion, could potentially be harmful to you or the public, I will highlight this to you and provide you with information on where you can seek support from your university.

7 – Should you have any questions following the focus group you may contact me by email at XXXX and I will respond and /or meet you to discuss.

Please sign this form to indicate that you are happy to participate in the focus group and have read this form.

If you wish to review the focus group record, please provide the email address you want the transcript to be sent to :

Appendix Eight - Interview questions with nursing students

Opening Question

1.0 Please describe what you consider makes a 'good nurse'?

Further Prompt Question (if required)

1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?

2.0 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?

Further Prompt Question (if required)

2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?

3.0 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?

Further Prompt Question (if required)

3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?

4.0 Describe your experience and what it is like when working with a 'good nurse' during clinical placements

Further Prompt Question (if required)

4.1 Describe how working with a 'good nurse' on clinical placement influenced your learning

5.0 Describe your experience of working in the clinical environment with others and how this influences and supports your learning

Further Prompt Question (if required)

5.1 Give an example of how others in the clinical environment have helped you to learn

Appendix Nine - Focus group questions with nurses completing a mentorship programme

- 1.0 What does it mean to be a 'good nurse' ?
- 2.0 How do students learn to be 'good' nurses ?
- 3.0 What elements of nursing care can't be taught or learnt in the classroom but can in the clinical environment?
- 4.0 How do you know that students are learning effectively when on a placement
- 5.0 What stops students from learning effectively on placement ?
- 6.0 Based on your experience how do nursing students learn from you when on clinical placements ?

Appendix Ten - Case study responses to the student interview questions

Participant / Question	Q1 Please tell me what you consider makes a 'good nurse'?				Q3 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?		Q4 Describe your experience and what it is like when working with a 'good nurse' during clinical placements		Q5 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	
Category	Becoming a Professional				Learning in the Clinical Environment		Influence of Registered Nurses on Learning		Influence of Others	
Student Participant 1	a nice caring person	need to know your boundaries	you meet a really good... say mentor and you think... oh yea you know I quite like to be like	I would have been I think I would have told myself don't get as upset as much ...	the ward environment the basics you know routine of a ward	I don't know how you do know	she was really nice to me	A bit of both first she was describing and then she showed me and sort of said do you, are you comfortable to take part in the next one yea and relaxed as well even when she was watching me I didn't feel like she was judging me or anything you know sort of you know	when you said others I immediately thought of other student nurses and when there is too may of them of student nurses on the ward it is a bit of a it sort of it almost like you are competing and it's a horrible feeling especially if you are not the most confident of people and you think uh and its easy to pass up chances you know if you get a chance to do something its easy to pass up and say oh Ill just watch the student do it you know	at the end of my second year there was a first year and em I remember being like her timid and nervous just like telling her how to use the blood pressure machine and things like that ... I remember thinking ... it makes you feel a bit more that you have actually learnt a bit and you don't really realize you do until you start telling someone erm it kind of can support you but it can also hinder you if there too many and if
	be intelligent	understand about all the drugs								
	be quite hard									
	to sort of get over things		I think a good nurse as a mentor is someone that is you know they are on the same level as you and you agree with you know with a lot of the things they say and just and they treat patients well	but I think I've met a lot more er..... erm..... not really nice people and I was surprised at how as its meant to be a caring profession ... that I'm surprised that there is so many just not very nice people really						
	quite open minded									
	actually does care									

			as well			<p>a feel about what you need to learn</p> <p>There might be one day where it was a good day and they might say ah yea your doing you know you had a good day today well done but I think it generally I think if yea if would be more if I was lacking and skills maybe say something</p>	<p>she was really nice and she was very intelligent as well I think that makes a big difference she explained what she was doing but she also she was talking about erm you know the evidence behind it I think she was just very intelligent and I know you just I she was really very good.</p>		<p>and eh so when there's too many it can be a bit like erm</p>	<p>there's another like annoying student and erm yea a few little put downs maybe by a few of the students I have had It is quite to have another student there for support see a face you recognize, there's positive and negatives I think</p>
Participant/ Question	Q1 Please tell me what you consider makes a 'good nurse'?	Q1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?	Q2 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?	Q2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?	Q3 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?	Q3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?	Q4 Describe your experience and what it is like when working with a 'good nurse' during clinical placements	Q4.1 Tell me how working with a 'good nurse' on clinical placement influenced your learning	Q5 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	Q5.1 Can you give an example of how others in the clinical environment have helped you to learn ?
Student Participant 2	<p>you have to care about what you do communication is another one that's</p>	<p>I think they are similar qualities</p> <p>I think they would be similar but know where the barriers sort of is for the</p>	<p>I think you see bad practice and I have seen it and I have said I don't want to be like that</p> <p>People who go out of</p>	<p>nursing was in a hospital and actually there are so many settings and so many streams</p>	<p>patient interaction with ill people</p> <p>you can't be taught how to interact or talk</p> <p>I find observation is my main thing on placement , I like just watching</p>	<p>I think you have your own idea of what you would like to do</p>	<p>One word that comes to mind is motivating</p> <p>if you have a good day you think, yes that's what I want to do, if you're included</p>	<p>Yes I think you want to learn, if someone seems un-motivating and doesn't want to help you.... You're like I don't really</p>	<p>Other members of the MDT like even I think what's helped me is the physios like going out with them it helps your manual handling and it helps things like that</p>	<p>watching what they are doing like the observation again , watching other people and like when they explain things to you, you kind of listen to it and really it if that</p>

	when they stop becoming a good nurse and it becomes more of a job rather than something you want to be doing	professional you have to have those qualities you know professional in your manner about it	their way to spend extra time with someone If you're with a nice team that as a student make you feel welcome and you actually want to learn there it makes all the difference and you say oh I'd like to be like that when I qualify		what other people do and you pick up everything			care whatever but if they are and encourage you to do things then you think yea I want learn and you might whether its go away and look at something in a text book	I went with the continence team which was interesting and you get you pick up things from that and you apply them to the clinical setting	makes sense
Participant/ Question	Q1 Please tell me what you consider makes a 'good nurse'?	Q1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?	Q2 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?	Q2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?	Q3 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?	Q3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?	Q4 Describe your experience and what it is like when working with a 'good nurse' during clinical placements	Q4.1 Tell me how working with a 'good nurse' on clinical placement influenced your learning	Q5 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	Q5.1 Can you give an example of how others in the clinical environment have helped you to learn ?
Student Participant 3	someone who is approachable honest responsible professional trustworthy	I think in the sense that I mean professional as well as being sort of jolly and happy and friendly and having a relationship with your	I think there's a lot of leadership skills that a nurse, a good nurse needs to have I've only sort of realized and learnt	basically the importance of being like ... maintaining your interest in being a nurse and being sort of Keeping you alive in a sense ...because its very easy and	Loads of things like ranging from erm .. just knowing what a nurse does because I'm sure I didn't know before erm before my first placement like the running of a ward ..the day sort of	I think we knew well I knew what I needed to achieve through erm the lectures we had before ...the placement which link into the placement I had a really	I think it makes a massive difference to your confidence it just makes you feel a lot more positive and happier about what	I suppose one thing I haven't said is it ... erm if I'm working with a good nurse who is interested in a certain thing ... it sort of sparks my	I think you feel a lot more responsible and ermautonomous I suppose and like erm ... so yea I suppose it would be different and I think it makes you feel a lot more erm ...like you're	My experience of working ..I haven't worked with that many other students but erm I think I tend to take the leadership role sort of thing and maybe like to eh .. sort of teach them things

	y nice but also hardworking	patient you have to also do your job properly	from through being on placement because you can only before being in that environment you can have a view you can know what ... what nurses do on a day to day basis as such It's the actual little things that you actually see on placement that you wouldn't be able to know before	its obvious being on placement and seeing it that nurses can become just ...kinda run down by the system in a sense and maybe bored to maintain high standards of being a good nurse and providing good nursing care you've gotta keep people sort of on their toes challenged and educated ... up to date about nursing	... erm ..daily ...I cant think of the word ...yea routine ...and how .. where you're supposed to be at what time and yea ..there's noting more confusing than going onto a ward on your first day and just feeling like you're in the middle of chaos the different roles in nursing like sisters and erm staff nurses, things like that how to do CPR, all that, all those kind of clinical skills we're taught in the classroom before we go but ...it's very different giving an injection to a real person who might be terrified of needles to doing it on a little dummy of an arm	good mentor in my last placement and she was very keen to know what I wanted to learn and helped me	you're doing and like you're valued you can be sort of as good as everyone else and also if you're working with a good nurse some of the excellent nurses I've seen or worked with do seem to have it all from what I've seen	interest in that certain thingbecause their so .. I don't know passionate about it... so it definitely as well as being interested in a specialty ...it just makes me feel like you know I actually want to be a nurse (laughs) and erm .. this is why I'm doing what I'm doing ...and erm ...so it influences you in a sense I think but it makes you more interested Just sort of happy and walk around with a sense of achievement and erm contentment with what	on your own and you have to perform (laughs) and yea it challenges you more because you haven't got your mentor to rely on	
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								they're doing and they still got the erm .. sort of empathy and compassion that you have to have with the patient erm ... and yea ...it's the same with every patient		
Participant/ Question	Q1 Please tell me what you consider makes a 'good nurse'?	Q1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?	Q2 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?	Q2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?	Q3 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?	Q3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?	Q4 Describe your experience and what it is like when working with a 'good nurse' during clinical placements	Q4.1 Tell me how working with a 'good nurse' on clinical placement influenced your learning	Q5 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	Q5.1 Can you give an example of how others in the clinical environment have helped you to learn ?
Student Participant 4	care and genuinely got into the profession to look after patients they have time to talk to the patients	you have to be quite confident and have that confidence they can separate professional from personal but they have this kind of like banter line	Yes so when she then told me I wasn't confident enough I was like no I was standing back because I wasn't happy with what you were doing you pick up on different characteristics that you want to have	I think it definitely has changed but then I didn't have much knowledge in the first place	I've never had to deal with patients you've never had to deal with families you've never had to deal with someone dying never had to deal with and you cant teach those things I think you have to experience them and then reflect on them so I think it would be better to do it the opposite way	my CAP document which is a very odd document in yourself you know what you after being in a placement two weeks or so you know what opportunities are available you know what you can do and what that's not going to be available	I felt like a good nurseI felt like I was being treated as a nurse rather than a student or a HCA let me write all the notes they just checked them I was given responsibility erm and then at the same time I was	You just want to learn if you've got someone whose good at their job that's how you want to be if that makes sense ... so it makes you want to learn you want to	On my last placement the physios were amazing she really was like I don't really know what I can teach you but and she really helped me understand the more rehabilitation side of things intermediate care in the community Physios generally are quite good if	I've been on placements with other nursing students, it's quite difficult when your off duty is different as well but erm there's kinda been good and Its kind of funny, peoples attitudes towards their placements as well like some people take sick days quite a lot and you just think

		<p>or that you don't want to have or don't want to be like</p> <p>I think everyone has the kind of like conception of a nurse being that kind caring person who is just lovely and everyone thinks nurses are these well most of them are these kind of like really lovely beings erm..... but then as you actually go into nursing I think you have a realization that although you have to be like that you have to have quite a lot of good time management , quite a lot of other skills as well as those skills that sometimes</p>		<p>round in that you do it and them come back and say this happened and they can be like ...</p> <p>people can say oh the NMC code says this and it says that I don't think you actually understand it until you go on placement and you think oh I cant talk about that patient because of the confidentiality you don't understand that</p>	<p>On other placements they've been like oh you've been really good but they haven't there's no other feedback like there's been oh you need to work on this but then they're quite quick to tell you when you've done something wrong ...but at the end of the placement they don't say what you can work on even though they've pointed out you've done things wrong ...</p>	<p>given the responsibility in the knowledge I could go and ask them if I didn't know</p> <p>And then they said that if I didn't understand to go to them which was nice to have that reassurance that they wouldn't see it as I didn't know what I was doing it would be seen as me just going to them for advice which a lot of nurses I think don't do if they don't know</p> <p>its kind of more like more of an equal to them and they were really trying to extend my learning and really they wanted to help me and they wanted to have like they</p>		<p>you ask to go with them as well like when they're seeing your patient ... if you ask to go with them there generally and they will explain it to you afterwards and give kind of feedback afterwards what they did why they did it what they want to do so</p>	<p>.. hmmand other students are really enthusiastic and in the end of it kind of, you end up teaming up with them And you kind of take it in turns to do each others jobs on the day and that two students you kind of have the equivalent ... on placement you discuss your patients in the sense if you're on the same ward you can say oh what do you think of this patient oh I don't really understand that do you understand it ?</p>
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			those skills contradict each other like listening to the patient but good time management and getting all your clinical jobs done there's a really hard balance to be made between them				wanted to have a good impression on me I think what allows them to do it is that their quite confident in their practice so they have the confidence to be able to teach you if you ask questions for them to be able to answer it			
Participant/ Question	Q1 Please tell me what you consider makes a 'good nurse'?	Q1.1 What are the qualities and abilities such a nurse would need to have to be competent and professional in your opinion ?	Q2 How did your view of what it means to be a good nurse develop during your experience on clinical placements ?	Q2.1 Based on your clinical experience how have your views about nursing and nurses changed since starting your course ?	Q3 What aspects of nursing care can't be taught or learnt in the classroom but can in the clinical environment ?	Q3.1 How do you know what you need to learn when on placement and how do you get feedback on how well you are doing ?	Q4 Describe your experience and what it is like when working with a 'good nurse' during clinical placements	Q4.1 Tell me how working with a 'good nurse' on clinical placement influenced your learning	Q5 Describe your experience of working in the clinical environment with others and how this influences and supports your learning	Q5.1 Can you give an example of how others in the clinical environment have helped you to learn ?
Student Participant 5	can make assessments that are holistic really good with their patients somebody that's really knowledgeable	Maybe good communication	I just thought nursing was just a job now its so much more complex like my understanding of nursing is much more complex	I probably thought it was a lot simpler than what it is now there's all the policies you have to adhere to I've got a feeling of when your doing	the main one is assessing patients like procedures simple things like taking out a cannula and now were learning about intubation dealing with like death	a lot of it is with our CAP documents it up to us to decide with our mentor do we need to do anything tell me what I need to do	It makes your shift go so much smoother and nicer and you enjoy the placement so much more just even if you work with one good nurse one day in the whole placement	Yea maybe they'll point out a few things that maybe you could look at so a case of we've done this procedure why don't you have a look at the policies or	where I had a few days with the physio and the occupational therapist and I just thought that they really helped me see the connection between the whole MDT because it meant what they learn and what they	doctors, I've found have been quite good , not all doctors , the main doctors that I've had had amazing experience have been on my elective and they ... 'cause it was just a small practice with like 8 doctors and 2

	<p>somebody that's good with their students and doesn't just take over but lets them talks them through it</p>			<p>nursing for a long time it might change your character there's certain people that would make amazing nurses</p> <p>you can see which ones are good and which ones aren't so good</p> <p>there is some lovely nurses that you meet in practice and some that you do just think why are you a nurse ?</p> <p>It's bad to say but it is and I do think to myself sometimes I wouldn't be nursed by you and I feel sorry for my patients and then I just go and do a bit of talking and try and make them be comfortable ...</p>			<p>that's the highlight of your whole placement</p> <p>so not only are you with a lovely nurse you've also enhanced your learning ten fold from the other days when you've been with a bad nurse..... its so much nicerI think it's the way that they relate to you</p> <p>so they sort of see you as an individual and as on the same par rather than some menial student</p>	<p>why don't you have a look at an article and shows what you could have done instead of or then yea that's what they're usually quite good at doing</p>	<p>were teaching me I could then know for future how to refer or who to refer on to for future patients</p>	<p>nurses it was, they would always get me into their erm consultations and explain things and they were amazing it was a lot busier obviously in England so it meant means on the ward get to talk to the doctors but you sometimes get the opportunity and its quite nice when they explain things to you I had some nice doctors in England who have said oh do you know I'm doing or why am I doing this</p>
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Appendix Eleven – Analysis of student participant responses against four components of a social theory of learning

Components of a social theory of learning (Wenger, 1998)	Student 1	Student 2	Student 3	Student 4	Student 5
Learning as Belonging	<p>I think a good nurse as a mentor is someone that is you know they are on the same level as you and you agree with you know with a lot of the things they say</p> <p>There might be one day where it was a good day and they might say, ah yea you're doing, you know, you had a good day today, well done. But I think it generally, I think if yea, it would be more if I was lacking and skills maybe say something</p> <p>I think you also get a feel if you are sort of liked within the team ... if majority of staff are friendly towards you and stuff</p> <p>yea I think so if they are friendly to you and yea and just like trust you to do things and send you off and like know you will do it and not keep asking you but yea and also just at the end of the shift saying like thanks or whatever</p>	<p>you work with some people that just ... especially I think a good team helps as well ... If you're with a nice team that as a student make you feel welcome and you actually want to learn there ... it makes all the difference and you say oh I'd like to be like that when I qualify</p> <p>Learning your name, I think if you ... if people when you are in a team if you're erm ... If someone has got something interesting they'll say come and look at this .. come and see this do you want to do this ? do you want to do that ? as apposed to you having to always go and say have you got anything to do ? what shall I do ? ...yea and just including you in what they are doing</p> <p>you have to make the best out of a bad situation, like I tried to go out on lots of places and be with teams that actually wanted to have students and when you ring them up and say oh could I come ... oh yes please that would be nice .. erm ... and</p>	<p>I've had a good nurse that I feel has, I think it defiantly make you feel part of the team and like people actually look at you like you know what you re doing what you're talking about you have knowledge and skills</p>	<p>My first year was my worst year for mentors, my first mentor on my first placement said that I was rubbish(Laughs) and ... I didn't like the way she practiced so to me I was like ... oh my goodness if this is what nursing is all about I'm not sure</p> <p>I wanted as it was my first placement, I wanted to make a good impression and it did really upset me but then looking back on it now..... I'm a bit ...I know I'm ok now I've gained that confidence and I've seen better practice so I know I was right to do and act how I did</p> <p>throughout the day they gave me things to do they gave me a list of things at the end of the day wanted done let me write all the notes they just checked them I was given responsibility and then at the same time I was given the responsibility in the knowledge I could go and ask them if I didn't know And then they said that if I didn't understand to go to</p>	<p>yea its hard when you've got a mentor that doesn't seem to want you as a student or doesn't want a student at all, it's really hard cause your not trying to impress but you wanna make sure you doing everything properly that it doesn't matter if you do everything right or nothing right either way you won't</p> <p>ye instead of student, that's not very nice when everyone's like, 'student ! can you do this' and 'I'll get the student to do it', its not very nice you just you know don't feel like anything even if its not you just think to yourself I've come into placement and I've learnt every patients name and everyone of your names why can't you remember one name?</p> <p>usually with the good nurses they're the ones that either want get you to do things so not only are you with a lovely nurse you've also enhanced your learning ten fold from the other days when you've been with a bad nurse..... it's</p>

Learning as Belonging

you have to try and put yourself out there but in a team finds it hard like just to include you and to show you bits, you find it hard to integrate and always feel like an outsider ... student do this ... student do that ...and I think a name does make all the difference ... yea its not difficult

Yea I think so because you miss out on quite a lot of things you could see if people were including you ... like yea my placement just gone I was told when I came in ... discharge planning would be a main thing of it ... I didn't do a single one ... like I think people find the time hard to manage and a student then becomes a hassle

I think you have to go all out to try and help with everything to put yourself forward and yea try and get the most out of it just to seem enthusiastic and I guess to learn what you can and like I guess if they see you like that then you would be seen to be a good nurse but if you just waited for someone to tell you what to do and you just went with the flow then I think you wouldn't

them which was nice to have that reassurance that they wouldn't see it as I didn't know what I was doing it would be seen as me just going to them for advice

its kind of more like more of an equal to them and they were really trying to extend my learning and really they wanted to help me and they wanted to have like they wanted to have a good impression on me

so much nicerI think it's the way that they relate to you erm so they sort of see you as an individual and as on the same par rather than some menial student they see you like, like..... like..... an individual like a human being sort of thing they see you as a student that needs to learn so they are gonna like help you learn and its like they take it upon themselves to say did you know this ? did you know that ?, how about we test this ? and it's more challenging

<p>Learning as Belonging</p>		<p>so they turned round to me and said I think you will be a good nurse</p> <p>One word that comes to mind is motivating, and it makes you, if you have a good day you think, yes that's what I want to do, if you're included, if you're encouraged and like you might not want to do something but they say go on do it you feel like oh I have achieved something to day and it just makes you want to be there</p> <p>Yes I think you want to learn, if someone seems un-motivating and doesn't want to help you.... You're like I don't really care whatever but if they are and encourage you to do things then you think yea I want learn</p>			
<p>Learning as Becoming</p>	<p>I think you put on a professional front</p> <p>but I think I've met a lot more ... not really nice people and I was surprised at how as it's meant to be a caring profession ... that I'm surprised that there is so many just not very nice people really</p>	<p>a good nurse they care and that they want to help people and I know that is quite a cliché, wanting to help people, but I do agree with it</p> <p>I think some people have had that element and then not got bored with it but it starts to lack and that's when they stop becoming a good nurse and it becomes more</p>	<p>if I'm working with a good nurse who is interested in a certain thing ... it sort of sparks my interest in that certain thingbecause their so .. I don't know passionate about it</p>	<p>so when she then told me I wasn't confident enough I was like, no I was standing back because I wasn't happy with what you were doing</p> <p>Not to be like her (laughs)I think the more people you meet as well the more your views change because you pick up on different characteristics that you want</p>	<p>I really wanna sort of improve because I've seen really bad practice in like in ...experience and it really scares me that when I come out of university I'm gonna think oh my God what, what if somebody dies I will have to tell their family because what I have seen it's a bit worrying though when 'cause you learn</p>

Learning as Becoming

I remember actually coming back home and being thinking that that's the kind of nurse I would like to be and I remember her like and I only worked with her one evening and I think it's made a difference

at the end of my second year there was a first year and I remember being like her timid and nervous just like telling her how to use the blood pressure machine and things like that ... I remember thinking ... it makes you feel a bit more that you have actually learnt a bit and you don't really realize you do until you start telling someone

of a job rather than something you want to be doing like

I think you see bad practice and I have seen it and I've seen it and have said I don't want to be like that

I don't think when I came in I didn't really, I didn't have any experience of nursing or anything so it kinda sounded like a nice job I sort of ... clichéd again ... I care about people and wanted to sort of improve things ... so I went in and I have just built on this finding out what they do I think I had the stereotypical view of what a nurse does, but now you've ... I've got a rounded view that yea .. that you do lots of good

and then you see the bad practice and you think right .. I do not want to be like that that.... that's not what a nurse should be

working with a good nurse who shows I can actually be a nurse but the placement that don't make you feel just unskilled I think that's it as well that you feel working with a good nurse who shows you things and helps

to have or that you don't want to have or don't want to be like ... I hope that I've taken something from each person that I was mentored by because they kinda helped me those placements helped me kind of develop into the nurse I am now

I felt like I was being treated as a nurse rather than a student or a HCA ..they said to me in the morning these are your patients you will hand them over

You just want to learn if you've got someone whose good at their job that's how you want to be if that makes sense ... so it makes you want to learn

everything in university but then you go on placement and if you don't have that experience then when your qualified you may have learnt something but you haven't had that placement so you haven't got a clue when your qualified obviously you cant do everything in placement so there's that little bit of uncertainty when you qualify ...

I think there's a certain .. you've gotta have a something about you to be able to have the qualities of a nurse so I think it kinda depends on your personality so then you can be a good nurse and you can be professional but I think with the ones that aren't so professional I don't know if its just because there on the wrong job or because they've had bad experiences have impacted on their attitude towards them and everything else and then their not very professional and they sort of don't wanna be there

sometimes its hard being the one good one in a bunch of bad

		you and whatever makes you feel yea do you know what, I can actually be a nurse, I can do these skills that you need like the more clinical sides of it, whereas if you don't you think what am I doing here ?			
Learning as Experience	<p>I think it's cause you meet so many different nurses that do things their way and you know everyone does it different its just you know it's not right or wrong</p> <p>'cause if you have a really bad day you think oh you know you don't feel that good where as you might have a good few weeks and one day might set you back</p> <p>asked me before we went into each patient did I want to do this and that and sort of like explained the background to them and explained what we would be doing</p> <p>I remember thinking that was you know she was really nice and she was very intelligent as well I think that makes a big difference she explained what she was doing but she also she was talking about you know the evidence behind it I think she was just very intelligent and I know</p>	<p>good people I have worked with nurses that make people laugh as well, like you have that side to you as well or you can be, you can have a serious side to you as well and get everything done but you can also you don't just do your job make everyone I don't know how to put it , you're not just working you interact as well and then you just get the people who do the paperwork, give out the drugs and that's that and the patient contact becomes a lot less</p> <p>you don't get the ... patient contact any more its all paperwork so yes you might be good in your job to get you up the bands but I don't think that makes you a good nurse at all and a sister I've just worked with didn't have the communication skills and I think went about her contact in completely the wrong way because she sits in an office all day and she</p>	<p>I think there's a lot of leadership skills that a nurse, a good nurse needs to have that I've only sort of realized and learnt from through being on placement because you can only before being in that environment you can have a view you can know what ... what nurses do on a day to day basis</p> <p>before I went on any placement I probably just thought of a good nurse as a nice person who could obviously do their job well but its the actual little things that you actually see on placement that you wouldn't be able to know before</p>	<p>everyone thinks nurses are these well most of them are these kind of like really lovely beings erm..... but then as you actually go into nursing I think you have a realization that although you have to be like that you have to have quite a lot of good time management, quite a lot of other skills as well as those skills that sometimes those skills contradict each other like listening to the patient but good time management and getting all your clinical jobs done there's a really hard balance to be made between them</p> <p>you learn how it works and like the tricks of the trade I think with nursing they don't have that time management there are ways that you can change and .. yea I think it definitely has changed but then I didn't have much knowledge in the first place... I had a very small knowledge base to then</p>	<p>I think I probably thought it was a lot simpler than what it is now I understand the, that there's all the policies you have to adhere to and there's now all the time constraints like in A and E</p> <p>as many examples as our lecturers give us you cant see the patients so its quite hard to learn how to assess unless you've got a patient in front of you</p>

<p>Learning as Experience</p>	<p>you just I she was really very very good.</p> <p>yea its always nice to work with other people just to see how they do it always reassuring when it's the same across the board</p> <p>I found that community nurses were nicer in their environment than the ward ... and I don't know if the wards make people ... less because it's a quicker turnover and I think you see so many different faces in like acute setting than in community maybe and you are a bit more hard in the hospital ... I don't know if that's anything to do with environments ... working environment and how you can stay a bit nicer because your working environment is nicer</p> <p>like the politics and things I think you don't realize and I didn't know what uniforms meant and who was sort of the top dog of things and I think you just learn from like experience and just think oh ok</p>	<p>directs everybody that actually in the wrong way because she probably hasn't been there for a while so I think yea I've seen that and you do pick up good practice that yea you like</p> <p>People ... I think who go out of their way to spend extra time with someone, like I know when people especially as a student you do it ... well ... I've tried to do it cause talking to especially I think the elderly get lonely and things like that and if you've got extra time go and sit and talk to someone ... like people want to be talked to and I think if you've got the extra time instead of just sitting and thinking oh what shall I do to go and interact with people</p> <p>I like just watching what other people do and you pick up everything ... I think with quite a lot of things .. I guess it's why bad habits get picked up as well just ... watching people</p>		<p>going from</p>	
	<p>so just the basics you know routine of a ward and what happens on it and stuff like that and then in terms of like</p>	<p>I think as well patient interaction with ill people, I think I found that quite hard when I came inI didn't</p>	<p>it just makes you feel a lot more positive and happier about what you're doing and like you're valued you can be</p>	<p>I don't think this course should be taught in a classroom ...I think it should be very much hospital based</p>	<p>we've got the dummies and they're really good but that's not real life and I know that I've done an intubation with a</p>

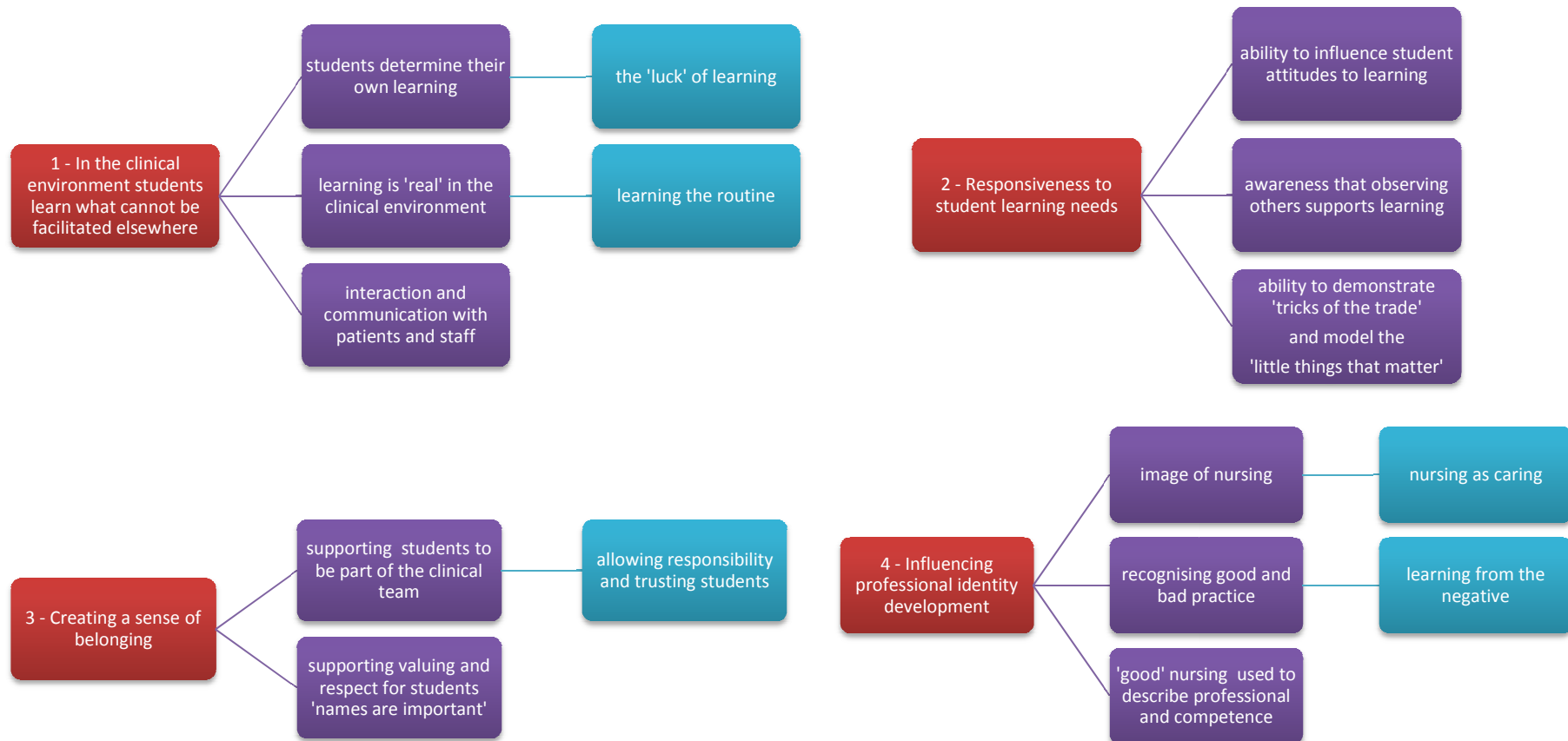
<p>Learning as Doing</p>	<p>... you know .. relationships and things you know you don't know with your mentor with staff and patients that obviously 'cause that can't be taught can it different patients and people that you meet</p> <p>but until you're there and you've got family members and different problems and you know short staffed and stuff I think its just a general feel of things</p> <p>first she was describing and then she showed me and sort of said do you, are you comfortable to take part in the next one yea and relaxed as well even when she was watching me I didn't feel like she was judging me or anything you know sort of you know</p> <p>I immediately thought of other student nurses and when there is too many of them of student nurses on the ward it is a bit of a, it sort of it's almost like you are competing and it's a horrible feeling especially if you are not the most confident of people and you think uh and its easy to pass up chances you know if you get a chance to do something its easy to pass up and say oh I'll just watch the student do it</p>	<p>know what to say to people I didn't know how to go about erm about my manner I don't know... when someone is acutely ill ... like I wasn't sure 'cause ... you can't be taught how to interact or talk</p> <p>You can't teach what someone is going to be like if they have an illness until you see it I think</p>	<p>sort of as good as everyone else and also if you're working with a good nurse ... you probably have a better chance to learn a lot more and learn the correct way to do things</p>	<p>rather than classroom based ...but then I think that's because I have to do things to learn them</p> <p>you could teach it to me in a class room but it wont do me any good I wont learn it 'till I do it until I kind of put an infusion or do the IV's physically do the drug calculations when the drugs are there</p> <p>and its that 'cause I've never I've never had to deal with patients you've never had to deal with families you've never had to deal with someone dying never had to deal with and you cant teach those things I think you have to experience them and then reflect on them</p>	<p>doctor and it was completely different to doing it on a dummy whereas if you base all your like your stuff on what you're learning in uni when you go out on practice your stuffed really cause its completely different its so different...</p> <p>I don't think you can fully prepare yourself, like even if people do read lots before they go on their placement because some of the things you need to do</p> <p>I think if you've got those nurses that will teach you how to do it it makes you as a professional probably better because you've learnt how to do it rather than just watched</p>
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Appendix Twelve - Student responses against NMC 2010 competency framework

NMC Competencies (NMC, 2010) / Student Participant	Student 1	Student 2	Student 3	Student 4	Student 5
Professional values	someone who actually does care, confidentiality, need to know your boundaries.	a good nurse they care and that they want to help people,	someone who is approachable, honest responsible, professional, trustworthy nice but also hardworking and professional	Someone who cares and genuinely got into the profession to look after patients you have to be quite confident and have that confidence	nurses that are really good with their patients you can be a lovely nurse and be brilliant with you patients but if you haven't got that knowledge you're not professional because you haven't got the information that they need to maintain good care
Communication and interpersonal skills	relationships and things you know you don't know with your mentor with staff and patients that obviously 'cause that can't be taught can it .. different patients and people that you meet	Communication, not just working ... you interact as well	and having a relationship with your patient	they have time to talk to their patients they can separate professional from personal but they have this kind of like, banter line	there are nurses that aren't very good at communicating and therefore their patients will suffer slightly so professionally they not as competent
Nursing practice and decision making	treat patients well		I feel a lot more responsible and autonomous you're on your own and you have to perform	have you done all their observations all their notes all their charts you just do those four patient washes and then you get to know that patient .. so then you can work on that during the day and then	make assessments that are holistic to a patient

				handing over your patient at the end of the shift shows to your mentor from the hand over in the morning what you've then done	
Leadership, management and team working	like the politics and things I think you don't realize and I didn't know what uniforms meant and who was sort of the top dog	I think she went about her contact in completely the wrong way because she sits in the office all day and she directs everybody in the wrong way	I think there's a lot of leadership skills that a nurse, a good nurse needs to have but seeing them sort of ... work in a team and sort of stuff and within sort of the nurse group ... its only then when you realize that you have to be able to lead and able to delegate appropriately	you have to have quite a lot of good time management	I could then know for the future how to refer or who to refer to

Appendix Thirteen – Overview of all four key themes and their associated sub themes



Appendix Fourteen – OU ethics committee letter on conclusion of research

Dr. Duncan Banks
Chair, OU Human participants and materials research ethics committee

REF : HPMEC/2010/830/1

September 11, 2012

Dear Dr. Banks,

I write with respect to my Doctorate of Education research that is nearing completion.

I can confirm that I undertook individual interviews with five final year nursing students and one focus group interview with eight registered nurses as outlined in my proposal.

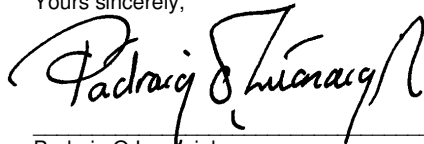
No ethical issues or concerns arose from my interviewing. Participants were provided with draft copies of their interview transcripts and no changes were requested.

I have also provided participants with the opportunity to comment on the draft themes arising from my work and one student responded with positive comments on the accuracy and future value of the themes identified.

My doctoral thesis makes no reference to participant names and I have maintained all consent to participate forms and the digital recordings in compliance with the requirements of the data protection act 1998.

I trust this update meets the requirements of the committee, I am of course happy to provide any further detail or information that you may require.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Padraig O Luainigh', written over a horizontal line.

Padraig O Luainigh